

**Diseases of Containment: Leprosy,
Syphilis, Law and the Construction of the
Diseased Body in Colonial South India,
1860-1900.**

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Contents

Abstract	3
Acknowledgements	5
Introduction	6
- Pathology	9
- Historiography	14
- Focus	23
- Approach	30
 Section One – Imagined Significance	 37
 Section Two – Law As A Cultural Marker	 58
 Section Three – Construction of the Visibly Diseased Body	 96
- Race	97
- Class	104
- Gender	111
- Space	125
 Conclusion	 137
 Bibliography	 141

Abstract

Between 1860 and 1900 the British Government in India – along with many other areas of the world – enacted numerous legal acts which superficially sought to prevent or control the transmission of disease. The implementation of legislative efforts attempted to identify and control subcultures that were marked as transmitters of infection. Thus legislation combined medical, legal and cultural concepts which formed the framework for the construction of societal control of infections.

The Madras Presidency offers two tangible examples of this association of medicine, law and society. The Cantonment Regulations (1864), which were the origin of the Contagious Diseases Act (1868), were introduced to control venereal disease, while the Lepers Act (1898) was directed at leprosy sufferers. These laws embodied the official response to two diseases which attracted significant attention in Victorian culture. Evidenced within these statutes are the cultural markers of the society which engendered them. This thesis compares these two acts and explores how these acts were the product of similar cultural mores. A thematic approach has been adopted to examine how these acts are consequently coloured by characterisations of gender, race, class, colonialism, politics and morality.

Leprosy and syphilis are biologically unrelated diseases. Prior to the twentieth century however, difficulties in diagnosis saw these two diseases often confused with one another. Additionally, these diseases were deeply stigmatizing and carried an imagined

significance out of proportion to their biological impact. This thesis analyses the way in which this legislation reified the corporeal form of sufferers. A visibly diseased body was constructed, which then allowed authorities to focus their efforts on the control of specifically identified groups, segregate them and render the visible invisible.

As a consequence of these pieces of legislation, marginalised groups were stigmatised as the visible carriers of disease and subjected to governmental restrictions by statutes that were embedded with the culture mores of the British in India, providing an illustration not so much of sanitary control but social control.

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Introduction

As we came nearer, the road was lined on both sides with rows of the most hideous deformities stretched on their backs and bedaubed with ashes. The poor wretches added to the horrors of their appearance by horrible outcries and writhings (*sic*). The blind, the maimed, the footless and handless leper, the hunchback, and the cripple lay stretched upon the ground begging for alms... Not far off were exposed to the gaze of all, men, women, and children, paintings of the actions of their gods—pictures too vile and filthy to be described, shamelessly shown as the deeds of the beings whom they worshipped as Gods!¹

This was how, in 1855, the Reverend John Dulles, a missionary in Madras, described a juggernaut festival. Dulles goes on to report the chaotic nature of the festival and that police were deployed to control the imagined excesses of the worshippers of *Jagannatha* and prevent any deaths. Encapsulated within Dulles' description are several recurring themes that emerge in an exploration of Colonial Indian society – visible disease, indigenous disorder and colonial control. Overt illness or deformity on the streets and apparent local apathy appalled European residents in Madras, as elsewhere in India. These exotic ceremonies were awkward reminders of the otherness of the local culture and the diseased bodies repelled and frightened British colonialists by illustrating the

¹ Rev. John Dulles, *Life in India or Madras, Neilgherries, And Calcutta*, (Philadelphia, 1855), pp. 103-4

health risks present in India. The expansion of empire throughout the tropics had exposed British colonialists to an array of cultural mores and illnesses. Tropical illnesses, in particular, generated fear in the European imagination and prompted appeals for solutions, particularly when the disease was seen as a threat to military authority in India. In the nineteenth century infection and contagion were understood to be the method of spreading diseases between people; although strictly speaking contagion represented transmission by contact, the two were generally conflated.² The need to manage these exotic diseases led to the development of the new science of tropical medicine and extensive efforts to eliminate infection. One of the key methods adopted by the colonial authorities was the introduction of legislation; laws directed at the control of specific diseases and at morally unacceptable behaviour. Legal rationale combined with medical expertise, and a growing belief in the superiority of western scientific advances, to create a structure that could regulate a seemingly chaotic society.

Ostensibly these laws centred on improving the health of the population. However, a more extensive analysis of them demonstrates an underlying social regulatory agenda and the exploitation of medicine and the nature of disease to support this. Government in India during the nineteenth century was white and British. Although in specific circumstances there were significant differences between these categories, the predominant presence of only one group in power in India and the focus of this thesis minimises the necessity to examine the divergence here. Consequently, the phrases white

²Alexander McCauley M.D., *A Dictionary of Medicine Designed for Popular Use*, 2nd Ed., (Edinburgh, 1831), p. 150

and British are used interchangeably here to refer to the non-indigenous population. For the British in India two particular diseases, leprosy and syphilis, generated significant social debate and controversy, becoming the subject of acts that centred on efforts to deal with the visibly afflicted. This link between health, society and politics formed the background to two pieces of British colonial legislation – the Lepers Act 1898 and the Contagious Diseases Acts of India and provides the focus of this thesis.³ As Rose has neatly stated:

Medical sites and personnel were bound up with the mutation of political thought into its governmental form, in which political authorities in alliance with experts seek to administer a diversity of problematic sectors, locales and activities in the population in an attempt to promote a well-being that has become inescapably ‘social’.⁴

The use of legislation, which exploited medical conditions to manage social issues, was not, of course unique to India. Similar policies were adopted in metropolitan Britain, where sanitation acts were implemented in an attempt to eliminate social issues that had arisen with the industrialization of Britain and the consequential urban concentration of the working class.⁵ There was a pervasive belief among the upper classes that the lower classes lacked moral fibre, and their resultant poor health was due to poor principles

³ Initially the Contagious Diseases Act was framed under the Cantonment Regulations Act XXII of 1864 and thus applied only to military bases. In 1868 the Contagious Diseases Act (India) extended this to civilian centres.

⁴ Nikolas Rose ‘Medicine, History and the Present’ in *Reassessing Foucault: Power, Medicine and the Body*, Eds. Colin Jones and Roy Porter, (London, 1994) p. 49

⁵ Frank Mort, *Dangerous Sexualities: Medico-moral Politics in England since 1830*, (London, 1987), p.65

rather than dire environmental conditions. In 1859 Mary Ann Baines noted that legislation could produce “an improvement in the moral and social condition of the working classes brought about through the natural relation that exists between the physical state and moral condition”.⁶ There was a persistent association between somatic well-being and spiritual virtue, an assumption that those who adhered to the socially-accepted moral norms were not prone to diseases of decadence. In the colonial situation these legislative endeavours were compounded with ideas of race, empire-building and economic necessities, although the perception of a large dissolute lower class continued as a central theme. In the Lepers Act 1898 those specifically targeted were ‘vagrant lepers’.⁷ An examination of the two acts implemented in India provides a prism through which to investigate many of the important themes of colonial power. This thesis explores the relationship between biology and cultural interpretation and how this relationship impacts on the treatment of sufferers of a disease. Further, the thesis considers how British authority sought to balance the public and the private, the visible and the invisible. Moreover, it examines how the acts were utilized in order to manage an enormous local population, while instigating an ill-defined policy of civilizing India.

⁶ Mary Baines quoted in Perry Williams, ‘The Laws of Health: Women, Medicine and Sanitary Reform 1850-1890’ in *Science and Sensibility: Gender and Scientific Enquiry 1780-1945*, Ed. Marina Benjamin, (Oxford, 1991), pp. 60-88

⁷ Lepers Act 1898 (Act No. III of 1898). The term leper has been used when referring to this specific act; otherwise it has been avoided in favour of less emotive terms.

Pathology:

Leprosy and syphilis are both bacterial infections that were incurable until the advent of penicillin and other antibiotic treatments developed in the twentieth century. Each had symptoms that, certainly with the progression of the diseases, were highly visible and disturbing. As well as this, each could prove fatal, normally after a protracted and painful illness. The means of transmission for each disease may be entirely different, historically though they have often been conflated and both suffer from certain moral prejudices related to their contraction. With the exception of the congenital form, syphilis is almost always spread by sexual contact and is a relatively easy disease to contract.⁸ By contrast, leprosy's transmission method is still not fully understood; currently the belief is that long-term exposure to nasal mucosa and infected skin lesions play a role. There is also thought to be a genetic component, with only some people even susceptible to the disease. In medieval Europe, there was a strong belief in a link between leprosy and sexual promiscuity.⁹ With the increasing presence of syphilis in Europe from the sixteenth century onwards and the sexual element of both diseases, mistaken or otherwise, the image of the two merged in the popular consciousness.¹⁰ Further reinforcing, or perhaps because of this, was the fact that diagnostically the two diseases were often mistaken for one another. Consequently, the moral judgements associated

⁸ Edmund C. Tramont, 'Syphilis in Adults: From Christopher Columbus to Sir Alexander Fleming to AIDS' *Clinical Infectious Diseases*, Vol. 21:6, (Dec. 1995), pp. 1361-1369

⁹ Saul Nathaniel Brody, *The Disease of the Soul: Leprosy in Medieval Literature*, (Ithaca, 1974), p. 129

¹⁰ Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS*, (Ithaca, 1988), p. 252

with leprosy in the medieval European mind combined with syphilis and resulted in both having implications of immorality that continued into the nineteenth century.

Syphilis infected hundreds of thousands of people during the nineteenth century. It is a disease with a high morbidity rate, but a low mortality rate. Infected patients can live with the disease for a number of years, thus enabling them to pass the disease on to scores of others. The cause of syphilis is a corkscrew-shaped (spirochete) bacterium, *Treponema pallidum*. It is part of the treponemal family, which includes Pinta, Yaws and Bejel – none of which are venereal infections. The causative agent was not identified, however until the beginning of the twentieth century.¹¹ Transmission generally occurs during sexual intercourse, but a pregnant woman can pass the infection on to her embryo. Unlike leprosy, syphilis spreads easily within a population. The disease has three stages – primary, secondary and tertiary. Initial infection is the first stage, which may only show a small lesion, secondary appears many months later and may have any number of symptoms. Because of syphilis's numerous symptoms, which can be mistaken for other diseases, it is often known as the great pretender. Tertiary syphilis may not develop until a decade or more after initial infection and causes joint disorder, heart disease, insanity and finally death. There was no test for syphilis until 1905, with the advent of the Wasserman test, nor was there a successful treatment until the arrival of Salvarsan around the same time; although penicillin would prove to be the most effective remedy against the disease. Syphilis creates visible lesions on infected genitalia a few weeks after initial transmission. If left untreated it will infect bones, joints and soft tissue, including the

¹¹Michael J O'Dowd, Elliot E Philipp, *The History of Obstetrics and Gynaecology*, (New York, 2000), p. 228

brain; eventually death ensues. There is significant contemporary academic debate over syphilis's appearance in Europe, with early theories identifying it as a 'new world' disease.¹² This is, in part, due to a famous outbreak in Naples which purportedly coincided with the return of Columbus' fleet from the Americas. Nineteenth century experts considered this to be the case.¹³ Syphilis, regardless of its origin, was well-recognised in the metropole, although the tropics supposedly produced an especially virulent form of the disease. With some knowledge of the method of contraction,¹⁴ but with no cure, British authority at home and abroad targeted what was seen as the primary vector – prostitutes.

Leprosy, in contrast to syphilis, affects far fewer people. Current scientific thinking suggests that only an estimated five percent of the world's population are susceptible to leprosy and of those, long-term, intimate contact is necessary for the infection to take hold.¹⁵ Biologically, it is an extremely difficult disease to contract. Understanding of the method of transmission is still quite limited. Although the leprosy bacillus, *Mycobacterium leprae*, was identified in 1873 as the causative agent, it is not readily grown in laboratory conditions. This makes it difficult to examine without the use of

¹² See for example, Alfred W. Crosby, Jr. *The Colombian Exchange: Biological and Cultural Consequences of 1492*, (Westport, Connecticut, 1972); K. Harper *et al.* 'On the Origin of the Treponematoses: A Phylogenetic Approach' *PLoS Neglected Tropical Diseases*, 2:1, (2008), pp. 1-13; Eugenia Tognotti 'The Rise and Fall of Syphilis in Renaissance Europe' *Journal of Medical Humanities*, 30:2, (2009), pp. 99-113

¹³ Dr E Lancereaux, *A Treatise on Syphilis Historical and Practical*, Trans. George Whitley, (London, 1869), p. 208; Alfred W. Crosby, *The Columbian Exchange: Biological and Cultural Consequences of 1492*, (Westport, Connecticut, 1972), p. 149

¹⁴ Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth Century Medical Discourse*, (New York, 1997), p. 6

¹⁵ Claude V. Reich, 'Leprosy: Cause, Transmission, and a New Theory of Pathogenesis' *Reviews of Infectious Diseases*, Vol. 9:3, (May/June 1987), pp. 590-594

stains and specialised culturing techniques.¹⁶ The nascent procedures that would identify cholera in 1885 were of little use on leprosy. It would not be until the twentieth century that there was the development of a method for positively diagnosing leprosy. The disease also has several distinctive pathological features including a gendered infection pattern. A late nineteenth century view suggested that males were more than four times as likely to contract leprosy as women, however modern studies suggest a ratio of roughly two to one.¹⁷ Added to this there is the long incubation period of the bacillus. The length between exposure and contraction can extend to years or just weeks. Father Damien, the Belgian priest who contracted leprosy whilst tending to leprosy sufferers on Molokai Island in the 1870s, served there for a decade before the disease presented itself.¹⁸ Therefore, without the ability to identify the disease and any immediately recognisable transmission factors, nineteenth century medical thinking expressed a variety of, sometimes imaginative, disease theories. These ranged from early genetic or hereditary causes to a dietary basis.¹⁹ This ignorance surrounding contraction and cure produced a mystery around leprosy that led to anecdotal, almost mythic, interpretations of the disease. Nineteenth century medicine could successfully identify neither cause nor treatment. In an age of growing western medical superiority the presence of leprosy in

¹⁶ Ibid.

¹⁷ One review gives a gender ratio of 4.38:1 male to female. H.V. Carter MD, Bombay Army, 'The Pathology of Lepers; with a note on the segregation of lepers in India', *Medico-Chirurgical Transactions*, (1873), pp. 267-284. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1988896/pdf/medcht00004-0337.pdf>. Modern studies suggest a combination of biological and cultural reasons for this gender bias. See for example 'Leprosy case detection using schoolchildren' G. Norman, G.A. Joseph, P. Udayasurian, P. Samuel and M. Venugopal, *Lepra Review*, 75, (2004), pp. 34-39

¹⁸ Father Damien first visited the Kalawao settlement on Moloka'i Island, Hawaii in 1873. He was reported as having contracted leprosy in 1884. Gavan Daws, *Holy Man: Father Damien of Molokai*, (Honolulu, 1984), p. 56

¹⁹ In 1863 Jonathan Hutchinson had postulated that leprosy was "Fisheater's gout" and caused by eating poorly preserved fish. There was also considerable debate over the hereditary/contagious nature of the disease. Olaf K. Skinsnes, 'Notes from the History of Leprosy', *International Journal of Leprosy*, 41:2, (1973), pp. 220-239

India represented visible evidence of the failure of the colonial 'civilizing mission'. Syphilis, by physically weakening the manpower of the British army, challenged the military power of the British army, which was the basis for British rule and self-justified command in India. In essence these two incurable diseases threatened mission and mandate.

Historiography:

The biological reality of bacteria, its taxonomy and pathology is intrinsically amoral. Cultural interpretations, though, imbue some illnesses with layers of morality, stigmatization and assumptions about the sufferer. Sontag noted that: "Any disease that is treated as a mystery and acutely enough feared will be felt to be morally, if not literally, contagious."²⁰ Certainly, leprosy and syphilis generated fear in the Victorian consciousness. These infections, due to biology and cultural interpretations, aroused a fervent response. Both diseases were incurable, physically debilitating, in their later stages, visibly repellent and contagious in the present as well as potentially for future generations. The overt presence of both diseases in India saw the nineteenth century British visitor faced with two frightening illnesses. Historically in Europe, leprosy and syphilis had encompassed many immoral inferences. This fear of moral corruption mingled with more recent ideas of societal evolution, imperial requirements and scientific thought to engender colonial responses that were more about control than cure. As Arnold notes, disease "acquires meaning and significance from its human context, from the ways in which it infiltrates the lives of the people, from the reaction it provokes, and

²⁰ Susan Sontag, *Illness as Metaphor*, (New York, 1978), p.3

from the manner in which it gives expression to cultural and practical values”.²¹ Leprosy and syphilis acquired meaning from this cultural milieu and came to represent more than just bacterial infection. They not only acted as symbols of certain social problems, their continued occurrence challenged Western scientific authority and colonial power. The often used, particularly since Sontag and Gilman, analogy of disease as a metaphor for social issues continues to have important analytical values. Certainly, for the Victorian there was a correlation between disease and social disorder.²² In a colonial territory, where small numbers of Europeans were governing a population as large as India, it was essential that any aspects of social disorder be contained. In this environment, public health legislation dealt not only with disease, but with the issues of empire as well.

This is the first time that a direct comparison has been made between the Contagious Diseases Acts and the Lepers Act. Previously, each has been studied as a separate creation and not part of the same process. Most of this earlier work has focused on the Contagious Diseases Act, with far fewer studies of the Lepers Act. The specific reference to women in the Contagious Diseases Act, as well as multiple amendments and its widespread reproduction throughout the colonial world has provided an insight into Victorian attitudes about class, gender, race and sexuality. Philippa Levine, in her extensive work, *Prostitution, Race and Politics: Policing Venereal Disease in the Empire*, argued that the fear of venereal disease and the resulting legislation were a significant part of nineteenth century political debates and in Britain and its colonies, the association of “promiscuity and disease, and between sexual desire and racial

²¹ David Arnold, ‘Cholera and Colonialism in British India’ *Past and Present*, No. 113, (Nov. 1986), pp. 118-151

²² Sander L. Gilman, *Disease and Representation: Madness to Aids*, (Ithaca, 1988), p.3

characteristics remained remarkably inflexible”.²³ Often considered as part of an analysis of Victorian sexuality, gender and prostitution in the British metropolitan milieu, or metropole as it has been termed, the Contagious Diseases Acts have helped to illuminate ‘official’ attitudes. Frank Mort contended that the Contagious Diseases Acts in Britain were tied in with other sanitary/public health acts, which attempted to regulate the urban poor and demonstrated the growing “medicalization of morality”.²⁴ Crucially, however, the acts differed from public health legislation in the specificity of their target. As only one group of possible sufferers was the focus, this law cannot be seen as a concerted attempt at managing the spread of the disease. Also of particular interest to historians, such as Walkowitz, was the correlation between the Contagious Diseases Act, poor working class women and prostitution. She examined not only the effects the British Act had on lower class women, but also the unlikely alliances that formed in opposition to the Act. Walkowitz also considers the use of prostitution as a metaphor for society, in terms of exploitation and pollutant.²⁵ The spatial reinforcement of the perceived hierarchical norms, which have been suggested as another function of the act, added further to the debate on class and sexuality during this period. Philip Howell demonstrated how regulations, earlier regionally specific by-laws as well as the Contagious Diseases Acts, created a geography of prostitution.²⁶ Space and segregation have proved to be significant factors in analysing gender roles in Victorian society, especially with the confinement of accused women to lock hospitals - facilities for treatment and

²³ Philippa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire*, (New York, 2003), p. 323

²⁴ Frank Mort, *Dangerous Sexualities: Medico-moral Politics in England since 1830*, (London, 1987)

²⁵ Judith Walkowitz, *Prostitution and Victorian Society: Women, Class and the State*, (Cambridge, 1980)

²⁶ Philip Howell, ‘A Private Contagious Diseases Act: prostitution and public space in Victorian Cambridge’ *Journal of Historical Geography*, 26:3, (July 2000), pp. 376-402

imprisonment - by the legislation. This can be seen in the work undertaken by Mahood, for example.²⁷ These categories of analysis, including class and gender were equally relevant in the colonial context.

The breadth of the colonial territories during the nineteenth century has ensured that there is an extraordinarily vast array of work reviewing aspects of the Contagious Diseases Acts. Colonialism's exploitation of the physical and corporeal geographies of the colonies has been well documented.²⁸ Spatial delineation was used as a way to emphasize hierarchies, such as class and gender roles, which were prevalent in the metropole. In the colonial world this spacialization also legitimized these hierarchies and functioned as an expression of racial hierarchy. The proliferation of Contagious Diseases Acts throughout the British Empire and the impact of exposure to differing environments have also meant that this type of legislation provided a unique perspective from which to examine colonial sexuality. Collingham explored the desire among colonialists to physically separate themselves from the colonised. She has suggested that perceptions of sanitation and the growing assumptions linking disease and the indigenous motivated this move towards segregation.²⁹ Hyam has studied the psycho-sexual elements of the British colonial experience as a part of the construction of empire and the consequences thereof, which included startling rates of venereal disease.³⁰ These rates were of primary concern amongst the military. Heyningen and Ballhatchet asserted that the contagious diseases

²⁷ Linda Mahood, *Magdalenes: Prostitution in the Nineteenth Century*, (London, 1990); See also Philip Howell, 'Race, Space and the Regulation of Prostitution in Colonial Hong Kong' *Urban History*, 31:2, (2004), pp. 229-248

²⁸ David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India*, (Berkeley, 1993); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race and Hygiene in the Philippines*, (Durham, 2006)

²⁹ E M Collingham, *Imperial Bodies: The Physical Experience of the Raj c. 1800-1947*, (Cambridge, 2001)

³⁰ Ronald Hyam, *Empire and Sexuality: The British Experience*, (Manchester, 1990)

acts, throughout the empire, were essentially a prop to British Imperial power.³¹ If this is so, then these laws necessarily supported the militaristic basis of that power, which was most threatened by venereal disease. The use of medical knowledge as a possible tool of empire has been much examined by historians such as Headrick.³² While there is considerable argument over exploitation of medicine as a tool of empire, the combination of medical knowledge and political power in a colonial setting would suggest that this was exactly what the Contagious Diseases Acts were.

The Contagious Diseases Acts specified women as the source of the infection and the impact this has had on the female population throughout the British Empire has been another significant field of study. The gendered basis of the acts has suggested several gender-based approaches in the exploration of venereal legislation. One of these has been the contribution of acts to the sexualisation of non-Western women, and as Edward Said suggested, the whole of Eastern culture.³³ Beyond this, has been the resistance and collaboration of women to the working of the acts. Women were more than just the subject of the legislation; they were also some of the key figures in the organisations, which protested against their introduction. Hodges in her work has considered the possibility that women themselves exploited the legislation during periods of famine and elected to enter the lock hospitals in order to secure food.³⁴ Whilst there are weaknesses

³¹ Elizabeth B van Heyningen, 'The Social Evil in the Cape Colony, 1868 – 1900, Prostitution and the Contagious Diseases Act' *Journal of Southern African Studies*, 10:2, (Apr. 1984), pp. 170-197; Kenneth Ballhatchet, *Race, Sex and Class Under the Raj: Imperial Attitudes and Policies and their Critics, 1793-1905*, (London, 1980)

³² Daniel R. Headrick, *Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, (New York, 1981)

³³ Edward W. Said, *Orientalism*, (New York, 2003)

³⁴ Sarah Hodges, "'Looting' the Lock Hospitals in Colonial Madras during the Famine Years of the 1870s" *Social History of Medicine*, 18:3, (2005), pp. 379-398

in her argument, it does evidence the agency of women in some of their choices, such as selecting whether or not to register under the act and assisting one another against authority. The Contagious Diseases Acts evidence a correlation between colonialism, sexuality, medicine and power. This correlation has produced some extremely interesting research.

Regulation of indigenous sexual behaviour as a means of managing the population, as discussed by Vaughan, acted to encourage stability.³⁵ Running in parallel to the investigation of the role of the contagious disease act on women, has been the changing characterisation of gender in the Victorian world. The increasing adoption of science as a justification for political decisions saw women placed at a biological disadvantage.

During this period Thomas Laqueur has shown that the humeral model gave way to the idea of “biological divergence.”³⁶ The divergent characterisations of women as both sexual predator and submissive recipient of man’s attention can be seen in a comparison of the Contagious Diseases Act with other gender based legislation of the period. As a foundation for study of Victorian society, the venereal diseases and their resultant laws afford numerous perspectives from which to explore a variety of fields. The sheer volume of work referencing these acts evidences the importance of them to historians.

By contrast, there is a far smaller body of work looking at the impact of the Lepers Act.

Whilst the body of work exploring aspects of medieval leprosy are considerable there is a

³⁵ Megan Vaughan, *Curing their Ills: Colonial Power and the African Illness*, (Cambridge, 1991)

³⁶ Thomas Laqueur, ‘Orgasm, Generation and the Politics of Reproductive Biology in the Making of the Modern Body’ in *Sexuality and Society in the Nineteenth Century*, Eds. Catherine Gallagher & Thomas Laqueur, (Berkeley, 1987)

substantially smaller amount exploring leprosy in the modern period. One explanation for this is the limited effect leprosy had on the metropole itself. Another is the small percentage of the world population which was affected by the disease. However, in terms of the fear and mystery that Sontag refers to, leprosy made a strong impression on the British imagination.³⁷ The reasons for this are the subject of some controversy. In part, the argument looks at the historical presence of the disease in Europe and an examination of the relationship of medieval leprosy to modern leprosy. Predominantly, whether the understanding of the disease continued through the centuries or whether the conceptual line was broken and rediscovered with exposure to the disease in exotic climes. Aside from the continuing debate regarding the taxonomic nature of biblical and medieval leprosy and whether or not these are indeed the same disease,³⁸ the stigmatizing nature of leprosy and the purpose that such stigmatization serves, as well as the nature of stigma itself, has become another focus for leprosy research.³⁹ Zachary Gussow argued that leprosy was re-stigmatized in the modern period and that this re-tainting broke from the medieval tradition.⁴⁰ However, the literary tradition of leprosy supports an unbroken belief. Saul Brody argues that a “tradition has survived because it is the expression of a complex array of cultural forces”.⁴¹ Leprosy fulfils all the requirements of a deeply stigmatising disease, as posited by Skinsnes, and from an historical perspective the

³⁷ Sontag, *Illness*

³⁸ See Margaret Lloyd Davies, T. A. Lloyd Davies, ‘Biblical Leprosy: A Comedy of Errors’ *Journal of the Royal Society of Medicine*, Vol. 82, (Oct. 89) pp. 682-3; Rebecca A Baillie & E. Eugene Baillie, ‘Biblical Leprosy as Compared to Present-Day Leprosy’ *Southern Medical Journal*, (1982), pp. 855-857

³⁹ See for example, Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, (New Jersey, 1963); Veena Das, ‘Stigma, Contagion, Defect: Issues in the Anthropology of Public Health’ www.stigmaconference.nih.gov/papers.html; W H van Brakel, ‘Measuring Leprosy Stigma: A Preliminary Review of Leprosy Literature’ *International Journal of Leprosy and other Mycobacterial Diseases*, 71:3, (September, 2003), pp. 190-197

⁴⁰ Zachary Gussow, *Leprosy, Racism and Public Health: Social Policy in Chronic Disease Control*, (London, 1989)

⁴¹ Brody, p. 197

impact of this stigma greatly outweighed the biological impact experienced by a population.⁴² In India, the colonisers faced a disease they found deeply disturbing and which they believed had been effectively eliminated from the metropole. This thesis takes into consideration the cultural position of the British when confronted with leprosy in an exotic location.

One feature of the European tradition was the link between leprosy and religion. During the nineteenth century this led to the adoption of leprosy as a cause by missionaries and other religious charities; eventually culminating in the foundation of Leprosy Mission in India.⁴³ Because of this correlation between leprosy and Christianity, a considerable body of work has focused on the potential for conversion amongst patients and the relationship of the missionaries to colonisation. Kakar argued that leprosy asylums were sites of conversion.⁴⁴ However, the existence of municipal asylums for substantial period before expansion of British authority and the late development of Christian hospitals would seem to counter this. In Madras, there had been secular facilities for leprosy care since the sixteenth century and a government leper hospital since 1840.⁴⁵ The position of missionaries was far more complex than that of simplistic seeker of converts, attending to the ill as an after-thought. Porter stated that missionaries “provided channels through

⁴² According to Skinsnes the 8 requirements are: External manifestation; Progressiveness; Non-fatal and chronic; Insidious onset; High endemicity, limited epidemic; Incidence rate associated with low living standards; Appear incurable; A Long incubation period. Olaf K. Skinsnes, ‘Leprosy in Society III: The Relationship of the Social to the Medical Pathology of Leprosy’ *Leprosy Review*, 35, (Jul. 1964), pp 175-181

⁴³ The Mission to Lepers in India was founded in 1874 by Wellesley Bailey an Anglican lay missionary and still operates today, www.leprosymission.org. It was followed by BELRA (now LEpra) – the British Empire Leprosy Relief Association, a secular organisation founded in 1924, also still operating, www.leprahealthinaction.org

⁴⁴ Sanjiv Kakar, ‘Leprosy in British India, 1860-1940: Colonial Politics and Missionary Medicine’ *Medical History*, 40, (1996), pp. 215-230

⁴⁵ Jane Buckingham, *Leprosy in Colonial South India*, (Basingstoke, 2002), p. 37

which Imperial controls followed, at other times it delayed annexation, or even subverted Imperial authority”.⁴⁶ In the West Indies, Baptist missionaries were even blamed for slave rebellions.⁴⁷ Although a support to the spread of the imperial mandate, missionaries also provided important local medical care and attempted to balance the requirement of indigenous health needs with that their mission and colonial authority, as Worboys has explored.⁴⁸ Discussion of the development of leprosy policy and the Lepers Act, however, has been of secondary importance, particularly as the act was only introduced late in the nineteenth century.

More recently, there have been investigations of leprosy within the modern colonial context. In particular, Buckingham’s seminal work *Leprosy in Colonial South India: Medicine and Confinement* helped to remedy the lack of study in this area.⁴⁹ Taking the beginning of British institutional leprosy care in the Madras Presidency as the starting point, her work examines the interaction between colonial authority, medicine and society, both indigenous and Indian-based European throughout the nineteenth century. Beyond this, Edmond has used a cultural approach to leprosy in the colonial world from the late eighteenth through to the mid twentieth century. His focus is very much on literary sources, where he explores the fear of leprosy and the growth of segregation of sufferers by the British.⁵⁰ There is research on the current effects of stigmatization, including Staples’ examination of the effects of social exclusion on a community of the

⁴⁶ Andrew Porter, ‘Religion, Missionary Enthusiasm, and Empire’ in *The Oxford History of the British Empire, Vol. III, The Nineteenth Century*, Ed. Andrew Porter, (Oxford, 1999), pp. 222-246

⁴⁷ Catherine Hall, *Civilizing Subjects: Metropole and Colony in the English Imagination, 1830-1867*, (London, 2002), p. 11

⁴⁸ Michael Worboys, ‘The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940’ *Osiris 2nd Series*, Vol. 15, (2000), pp. 207-218

⁴⁹ Jane Buckingham, *Leprosy in Colonial South India*, (Basingstoke, 2002)

⁵⁰ Rod Edmond, *Leprosy And Empire: A Medical and Cultural History*, (Cambridge, 2006)

leprosy-affected in modern day Southern India.⁵¹ The leprosy hospitals themselves also continue to offer an interesting starting point for examining issues of space, race and disease. Robertson has investigated the history of leprosy asylums in India and looked at the different forms that the asylum took as well as the variety of care offered.⁵² More recent research has explored the social implications of leprosy; Pati and Nanda, for example, have focused on the social history of leprosy.⁵³ Their work explores and compares traditional medical systems with colonial health care, as well as the lives of patients within asylums. Beyond India, researchers continue to examine the many aspects of this disease throughout the world, especially regions such as South Africa and South America.⁵⁴ Leprosy thus continues to provide for researchers a fascinating combination of health, culture, place and power.

Focus:

This thesis covers the period from 1860 to 1900. By 1860 the power of governance had been transferred from the East India Company to the British crown. Shortly after this, the first Contagious Diseases Act was introduced into India and for much of this period debate continued over the implementation of the Lepers Act. A comparison of the two

⁵¹ James Staples, *Peculiar People, Amazing Lives: Leprosy, Social Exclusion and Community Making in South India*, (Delhi, 2007)

⁵² Jo Robertson, 'The Leprosy Asylum in India: 1886-1947' *Journal of the History of Medicine and Allied Sciences*, 64:4, (2009), pp. 474-517

⁵³ Biswamoy Pati and Chandi P. Nanda 'The Leprosy Patient and Society: Colonial Orissa, 1870s – 1940s' in *Health, Medicine and Empire: Perspectives on Colonial India*, eds. Biswamoy Pati and Mark Harrison, (Hyderabad, 2001), pp. 113-128

⁵⁴ See for example, Harriet Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town' *Journal of South African Studies*, 22:2, (June 1996), pp. 287-308; Diana Obregon, 'The State, Physicians and Leprosy in Modern Colombia' in *Disease in the History of Modern Latin America: From Malaria to Aids*, ed. Diego Armus, (Durham, 2003), pp. 150-157

acts was the initial impetus for this work. A close examination shows the similarity of issues that framed the construction of these pieces of legislation. Further, with the exploration of the cultural mores surrounding the diseases of leprosy and syphilis a common social inheritance emerges. The choice of confinement as the primary function of the laws emphasizes the use of spatial delineation for the sufferers of both diseases. By defining the space, in which a person resided or worked, society consequently influences the visible presence of a person. When a specific group is banished from the community it is made invisible to the community. This thesis demonstrates how the Contagious Diseases Act and the Lepers Act attempted, unsuccessfully, to do just this to undesirable members of Indian society. The exclusion of these specific groups reveals the societal regulatory function and the restriction of visible disorder, which both acts shared. This work will show the similarity of response that vastly different illnesses can provoke, when cultural and political issues take precedence over the realities of disease control. The Contagious Diseases Act and the Lepers Act offer an interesting perspective from which to view the workings of colonial power.

Without doubt, a major influence when exploring issues of medicine and the architecture of power is the work of Foucault. Although, his work focused on Western society and when dealing with the colonial context, some of his work is of limited value, he has provided an important framework for debate. Certainly for this thesis, *The Birth of the Clinic* and *The History of Sexuality* have proved extremely useful.⁵⁵ The spacialization of disease and his work on the control of bodies are relevant to both leprosy and syphilis.

⁵⁵ Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, Trans. A M Sheridan Smith, (London, 1973); Michel Foucault, *The History of Sexuality, Vol. I: An Introduction*, Trans. Robert Hurley, (New York, 1978)

His work has also highlighted the use of government power to regulate the population, or bio-power. The Contagious Diseases Act and the Lepers Act evidence the use of bio-power in the regulation of specific groups within a society. These acts saw colonial authority attempt to protect an economic and military asset, as well as the subjugation of the indigenous body and the management of marginalised subcultures as underlying aspects of the treatment of the diseased. In one particular area, however, Foucault's work has proved less relevant. An essential element of any exploration of life in colonial India and its legislation is the impact of race and racial theories. His avoidance of race and his focus on a Euro-centric view of culture are common criticism of his theories.

Christopher Fyfe convincingly argued that colonial authority meant white authority and that all empires were racially ruled.⁵⁶ The colonial construction of the indigenous body, its exoticism, weakness and backwardness form the basis for many of the assumptions the British made regarding the Indian population. This was implicit in both in the Contagious Diseases Act and Lepers Act. Frantz Fanon called this process the epidermalization of inferiority.⁵⁷ In the British Empire, the colour of the skin conferred social position – white at the top, black at the bottom. This concept also suggests that despite education or wealth the non-white members of the Empire would be excluded from the upper echelons of the colonial elite. Race was also closely tied to the British concept of civilization and the development of a disciplined, productive society.

For the Victorian British colonialists, there was a desire to improve the lot of the childlike native and this was often the overt reason given for the introduction of

⁵⁶ Christopher Fyfe, 'Race, Empire and the Historians', *Institute of Race Relations*, 33:4, (1992), pp. 15-30

⁵⁷ Frantz Fanon, *Black Skin, White Masks*, Trans. Charles Lam Markman, (New York, 1967)

regulations – the establishment of schools and the call for the end of sati can also be seen in this category. The colonists were appointing themselves as civilizers and saviours, intent on rescuing the native. The colonial rescue fantasy, as Singh suggests, acted as the basis for Britain’s civilizing mission in nineteenth century India.⁵⁸ The tension between improving the natives and assumed racial inferiority was thus created by the colonialists’ own perceptions.

The concept of the civilizing mission is a phrase frequently mentioned in works examining the British in India, particularly in reference to the imperialism of the second half of the nineteenth century. The term civilizing mission was a translation of a French term *mission civilisatrice*, and assumed that French culture was superior and that human society would progress to a teleological apex.⁵⁹ Essentially, this concept was the drive by colonial authority to westernize local cultures, based on the idea that British European society was the epitome of civilization and that indigenous populations required help to set them on the correct path. However, here again this was a reflection of similar efforts in the metropole. The British definition of civilization had its foundation in the construction of metropolitan society. One that was based on an “industrial capitalist society, divided by class united in its nationhood, its Protestantism and its white ethnicity, with a gender order built on the notion of separate spheres for men and women”.⁶⁰

Indeed, it is the metropole that epitomized Foucault’s idea of “the controlled insertion of

⁵⁸ Jyotsna G. Singh, *Colonial Narratives/Cultural Dialogues: “Discoveries” of India in the Language of Colonialism*, (London, 1996), p. 80

⁵⁹ Michael Mann, ““Torchbearers Upon the Path of Progress”: Britain’s Ideology of a “Moral and Material Progress” in India’ in *Colonialism as Civilizing Mission: Cultural Ideology In British India*, Eds. Harald Fischer-Tine and Michael Mann, (London, 2004), p. 4

⁶⁰ Catherine Hall, ‘Of Gender and Empire: Reflections on the Nineteenth Century’ in *Gender & Empire*, Ed. Philippa Levine, (Oxford, 2004), pp. 46-76

bodies into the machinery of production”.⁶¹ Victorian authority at home and abroad sought, in part through the use of legislation, to regulate society and ensure economic prosperity. The manner of regulation, however, changed radically during this period and was manifestly different in this period to earlier periods. The imposition of somatic punishments was replaced by the intellectual. Discipline as a precept of civilized behaviour was internalized. This is evidenced in Ignatieff’s examination of the development of the penitentiary system, which systematized psychological punishment to enforce social order.⁶² Further, in this work, he stated that this response can be “seen as an element of a larger vision of order that by the 1840s commanded the reflexive assent of the propertied and the powerful”.⁶³ This desire for order was transplanted to India where power/knowledge and ideologies of race became synthesised as part of the justification and mechanisms of colonial authority. Following the events of 1857 and with the large population of the region, there was greater anxiety among colonisers, which prompted the more intense use of social regulatory techniques, particularly towards non-conformist sub-cultures. Mills argued that there was an “emphasis on surveillance and restriction of movement to render these groups visible”.⁶⁴ Whilst this may have been true in the case of those at the centre of the Criminal Tribes Act, for people infected with leprosy and syphilis where confinement of the visibly afflicted was adopted, the opposite was the reality.

⁶¹ Michel Foucault, *The History of Sexuality, Vol. I: An Introduction*, Trans. Robert Hurley (New York, 1978), p. 140

⁶² Michael Ignatieff, *Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750-1850*, (London, 1978)

⁶³ Ignatieff, p. 210

⁶⁴ James H Mill, ‘Psychiatry on the Edge: Vagrants, Families and Colonial Asylums in India’ in *Fringes of Empire*, Eds. Sameetah Agha and Elizabeth Kolsky, (New Delhi, 2009), p.193

As demonstrated with the Criminal Tribes Act, and other such pieces of legislation, law was used to reinforce the order and hierarchies of empire. The use of medicine as an equivalent prop is a matter of some debate.⁶⁵ However, the two in combination were a formidable asset to colonial authority in its attempts to manage the indigenous population. Public health regulations were an obvious example of this. Specifically, in this thesis, 'Public Health' refers to government attempts to improve or change the wellbeing of a population, as opposed to 'public health' which refers to the general concept of people's fitness. From an Indian perspective, however, as Arnold has noted, western medicine remained tainted by the idea of state control, and it failed to supplant traditional medical systems.⁶⁶ Although, colonial authority ensured that indigenous medical practice, while not displaced, was relegated to a secondary position. This can be seen in other contexts of the power/knowledge paradigm, where colonial authority attempted to render both native medics and certain diseases invisible. Along with traditional medical practitioners, traditional midwives, similarly, were an example of this drive to conceal the unacceptable. This occurred not just in India, but in other colonial territories such as Canada.⁶⁷ In general, Public Health laws tackled issues that affected large portions of the population and aimed at prevention, thus it focused on problems such as drainage for the prevention of cholera, vaccination against smallpox and epidemic disease control, such as outbreaks of bubonic plague. It is possible to argue that most of the Public Health laws were directed at protecting the European population.

⁶⁵ Daniel R. Headrick, *Tools of Empire: Technology and European Imperialism in the Nineteenth Century*, (New York, 1981)

⁶⁶ Arnold, *Colonizing the Body*, p. 3

⁶⁷ Myra Rutherdale, 'She Was a Ragged Little Thing: Missionaries, Embodiment and Refashioning Aboriginal Womanhood in Northern Canada' in *Contact Zones: Aboriginal and Settler Women in Canada's Colonial Past*, Eds. Katie Pickles and Myra Rutherdale, (Vancouver, 2005), p.233

Certainly, Kakar has suggested that the health of the indigenous people was peripheral to colonial interests.⁶⁸ The prioritisation of European health care over that of the indigenous population can partially be justified by the higher morbidity rates experienced by this group in India. Levels of illness and death for Europeans in India were substantially higher in most diseases than they were for the local population.⁶⁹ While the health of the colonisers was a priority, the Indian Medical Service did endeavour to improve Indian health including the establishment of dispensaries, laboratories and vaccination programmes from the early nineteenth century onwards. The dispensaries in the Madras Presidency alone saw hundreds of thousands of people each year, mostly from both European and Indian poorer classes.⁷⁰ These facilities and programmes were in part an extension of the saviour role that the British saw themselves in. Equally, it was a way to disseminate colonial ideas as the pre-eminent authority, thereby excluding traditional rivals.⁷¹ As Harrison has pointed out, public health efforts were often slow and regionally erratic, as well as restrained by finances, however expenditure did increase through the 1880s.⁷² From a purely financial point of view, it also made sense to protect the economic asset that Indian manpower represented.⁷³ As a by-product, the dispensaries and civil hospitals provided the Indian population with greater exposure to Western medicine and technology, which could serve to emphasize Britain's perceived superiority over the indigenous. As Arnold stated: "In India the authority and prestige of Western

⁶⁸ Sanjiv Kakar, 'Leprosy in British India, 1860-1940: Colonial Politics and Missionary Medicine' *Medical History* 40, (1996), pp. 215-230

⁶⁹ Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, (Cambridge, 1994), p.66

⁷⁰ Arnold, *Colonizing the Body*, p. 249

⁷¹ Arnold, *Colonizing the Body*, p. 293

⁷² Harrison, *Public Health*, p.201.

⁷³ Harrison, *Public Health*, p. 3

medicine and public health emanated directly from the state.”⁷⁴ Public Health regulations are, by their very nature, centred on the health of the population. Consequently, sections of the population can come to be seen as a cause of concern and the source of a problem. Subcultures that resist government efforts or oppose them can be marked as having contributed to development of their own situation.⁷⁵ Regulation then focuses on these marginal groups, rather than wider issues. This can be seen in the Lepers Act and the Contagious Diseases Acts. While ideas surrounding Public Health contributed to the construction of leprosy and syphilis legislation, as will be demonstrated, these two acts differed in many ways.

Approach:

The Lepers Act and the Contagious Diseases Acts were a product of their cultural and historical milieu. This thesis examines the society and the time that this legislation grew out of. Further, the diseases of leprosy and syphilis are explored in the context of Victorian society. In large part, the societal response to these two diseases was based on an imagined significance, a significance that bore little relationship to the realities of any potential for infection. A major theme examined in this thesis is the perception of disease as an embodiment of non-corporeal paradigms, the idea that it is more than just a biological entity. In particular, this thesis looks at the interaction between visibility and authority. Previously studied separately, when the legislation is compared they evidence the workings of government power on the internal ‘other’, small, unwanted subcultures.

⁷⁴ Arnold, *Colonizing the Body*, p. 244

⁷⁵ Collingham, p. 165; Arnold, *Colonizing the Body*, p. 42

A three fold thematic approach has been adopted, investigating cultural, legal and social elements of the acts. The period under consideration in this work encompasses a time when India had come under British governmental control to the end of the Victorian age. While this thesis has limited its scope to the colonial period, manifestations of this type of authority still find expression in modern societies. Legislation is constructed imbued with cultural prejudices and assumptions, with sub-cultures being a continuing focus. The management of the visible image and the spatial restrictions of marginalized groups was a central theme of colonial authority; echoes of which can still be heard today.

In order to understand the impact and perceived necessity of the legislation, the diseases themselves should be understood. These diseases shared many cultural parallels despite their unrelated biology. The Victorian understanding of them and how this developed, explains much about the connection between them. Section one, 'Imagined Significance', considers the cultural importance of leprosy and syphilis. This section examines the imagined significance of these illnesses and the response this engendered. An analysis of the Victorian perceptions of these diseases provides an insight into the framing of the legislation and the treatment of the sufferers. Morality, social hierarchy, religion and science all attached meaning to syphilis and leprosy. Crucially, leprosy and syphilis had pronounced visible symptoms. The importance of this visibly diseased body is a key consideration of this thesis. Further, because of their incurability, both diseases challenged the superiority of western medicine – a feature of the moral justification of Empire. In European culture, both diseases placed the afflicted on the outside of society. The interpretation placed on the contraction of leprosy and syphilis transformed leprosy

sufferers into victims in need of rescue, while syphilis sufferers had earned their fate. While some of the motivations for these perceptions have a similar basis there are examples of differences of emphasis for both diseases. Syphilis and the Contagious Diseases Act were closely linked with prostitution, Victorian sexual behaviour and perceived gender roles. Leprosy, by contrast, was perceived in terms of race and poverty, although there were some allusions to sexual transmission. Most noticeably for both diseases was the stigmatisation imparted to all the sufferers. These perceptions were not, however, exclusive and as will be demonstrated there was a number of similarities. Much of the significance attached to leprosy and syphilis was almost illusory or created by the colonialists themselves, however, it did deeply influence their reactions. One important feature of the social response to these two diseases in India was that British authority sought to exclude certain sufferers based on the visibility of their disease. The sufferer of leprosy and the sufferer of syphilis shared many of the same characterisations and the resultant similar treatment by society.

Syphilis, which supposedly only arose in Europe in the late fifteenth century, was the first to engender laws surrounding its transmission, with the introduction of the Contagious Diseases Act 1864. Leprosy, by contrast, was known to have had a much longer history in Europe, did not provoke legislation until 1898, with the introduction of the Lepers Act. Section two of this thesis, 'Law as a Cultural Marker', explores the two pieces of legislation themselves. It develops the idea that laws not only encompass cultural mores, they also contribute to the construction of them. The implementation of the Contagious Diseases Act and the Lepers Act reified aspects of the diseases they sought to control. In

this way, the law acts as a measure of the degree of social management and the level to which cultural factors influenced government and motivated the framers. This thesis also considers how these two pieces of legislation were used as part of the classification of Indian society, especially as both were the product of colonial authority and founded on European precedent. Local traditions acknowledged degrees of infection and were slow to reject the afflicted from communities, if at all. The Contagious Diseases Acts and the Lepers Act, by contrast, was grounded in European traditions of exclusion. The government in India during the latter half of the nineteenth century was an extension of the British parliament based in the metropole. De Souza, Buckingham and Waligora have all explored the interaction between colonial and indigenous law in the establishment of the Indian legal system.⁷⁶ Although for leprosy and syphilis local religious law and traditions seem to have had little impact on the construction of the acts designed to control them. This thesis, then undertakes an examination of the tensions that developed following the introduction of the Acts. Legal theory was often at odds with the realities of instigating a law, the practicalities involved in the enforcement of the LA and the Contagious Diseases Acts, as well as the effectiveness of the legislation. Finally, the controversy that surrounded both sets of laws is considered. Where possible, local reports have been used to provide an insight into opinions regarding these acts and their consequences; on the whole however there was limited concern expressed over the fates of vagrant leprosy sufferers or poor prostitutes by indigenous elite. Indian elites,

⁷⁶ Valerian De Souza, 'Strategies of Control: The Case of British India' *Sociological Viewpoints*, (Fall 2008), pp. 61-74, www.pasocsociety.org/ARTICLE5-deSouza.pdf ; Jane Buckingham, 'Morbidity Mark: The Place of the Leprosy Sufferer in 19th Century Hindu Law' *South Asia: Journal of South Asian Studies New Series*, XX:1, (June 1997), pp. 57-80; Melitta Waligora, "'What's your Caste?'" The Classification of Indian Society as Part of the British Civilizing Mission' in *Colonialism as Civilizing Mission: Cultural Ideology In British India*, Eds. Harald Fischer-Tine and Michael Mann, (London, 2004)

however, were keen to protect their position and their civil rights against potential abuses of a law which would allow for unlimited incarceration. Both the Lepers Act and the Contagious Diseases Acts attempted to avoid local controversy and the possibility of upsetting local elites by their careful choice of target. It is also notable that with leprosy the debate came first, followed by the legislation; whereas with syphilis, the legislation was following by lengthy debate. The combined period of legislation and debate was approximately the same for both diseases. This, along with a number of other commonalities, is the reason for the comparison of these two acts. The Acts were excellent examples of the social and political value of disease and how cultural and political imperatives influence legislation, often to its detriment.

Both the Contagious Diseases Act and the Lepers Act attempted to confine the sufferers of illness with obvious physical markers, however, not only did these signs have to be visible on the body, they had to be visible to the public. Section three, 'Construction of the Visibly Diseased Body' investigates the creation of the diseased body and the tension between the visible and invisible, between public and private space. For the British public, the efforts to control visible subcultures in society also provided evidence of the government's efforts towards the civilizing of the Indian culture. Authorities were aware that leprosy and syphilis sufferers, particularly of the middle classes with sufficient resources, retreated to private spaces or travelled abroad and could transmit the disease. The nature of leprosy and syphilis meant that only the visible could be controlled. Consequently, authorities focused on the disfigured and on those who were made visible in the streets because of poverty and resorting to begging or prostitution to earn a living.

Discussions by colonial authorities in India regarding efforts to control the movement of leprosy sufferers date back to the 1840s.⁷⁷ The Contagious Diseases Acts and the Lepers Act, however, sought only to confine and thereby, render invisible those who manifestly had these diseases and were present in public spaces. Ironically, this exploitation of legislation to conceal the presence of specific groups also had the effect of bringing about their revelation. In one sense, the disease had first to be embodied, before it could be concealed. The constructed diseased body was embedded with cultural characterisations that reflect the assumptions of Victorian society. The targets of the acts were shaped by race, gender and class which as Bashford has asserted was also the basis for the treatment strategies.⁷⁸ These two groups, vagrant leprosy sufferers and women with venereal disease servicing Europeans, represented a visible other, marked by disease, marginalised and without the means to access those who had the power to alter the acts. Once sufferers were identified, the space they inhabit can then be contested. The allocation of space was a crucial physical marker of identity and social position in Colonial India. The legislation established penitentiary/medical spaces for those found in breach of the law; places designed to confine and conceal visible sufferers. The effectiveness of these spaces was questionable both in their function as hospital and as jail. It is the contestation between theoretical societal mores and the reality of societal demands that is explored in this section. Moreover, it examines the attempt by a society to balance managing the perception of a disease and achieving operational success. The Contagious Diseases Acts and the Lepers Act engendered a visible sufferer of a disease while at the

⁷⁷ Buckingham, *Leprosy*, p. 157

⁷⁸ Alison Bashford, 'Medicine, Gender and Empire' in *Gender & Empire*, Ed. Philippa Levine, (Oxford, 2004), pp. 112-133

same time seeking to confine and conceal the diseased body. Legislation, therefore defined both the biological form and geographical space.

The Contagious Diseases Act and the Lepers Act were examples of the utilisation of disease legislation as a component of colonial government power. The construction of these laws encapsulated Victorian preconceptions around race, class and gender. Cultural values are embedded in the acts and serve as markers to the society which created them. The acts also reveal the imagined significance that nineteenth century authority applied to specific diseases. This significance often disregarded the existing medical knowledge, reacting instead to political and social pressures. The legislation demonstrated government action, although not necessarily effectiveness. The Contagious Diseases Act and the Lepers Act concentrated only on the highly visible individuals; primarily the ulcerated poor. Due to the nature of leprosy and syphilis, control of the visibly diseased body and the space it inhabited became a central element of official efforts to manage both exotic illnesses and population. The examination of the construction and form of these two pieces of legislation offer an insight not only into the treatment of the diseased in Victorian society, but also the application of colonial power.

Section One - Imagined Significance

Despite little biological similarity, syphilis and leprosy infused the nineteenth century imagination. Beyond the purely medical was the deeply stigmatizing nature of both these diseases and each carried insinuations of physical and moral weakness. Along with a sense of moral corruption, European society perceived a threat to its well-being; in particular, the danger that the exotic posed to the metropole. Syphilis and leprosy were, certainly not the only foreign threat – cholera being an obvious example. However, both these diseases filled the popular British imagination, especially, in their grisly advanced forms. An explosion of pictorial journals in the metropole ensured that the burgeoning, literate middle and upper-classes had plenty of material to encourage these ideas.⁷⁹

Syphilis had also long been linked with the ‘other’, as a disease introduced by an alien community or transmitted by a sub-culture within a community.⁸⁰ The history of the names given to syphilis attests to this - called the French Disease by the Italians, the Italian Disease by the Germans and the British Disease by Pacific Islanders, its transmission was connected to the sexual profligacy of an alien group. Further, syphilis contracted abroad provoked greater fear than the domestic version. The popular idea being that the Asian strain was a more virulent disease than the European strain.⁸¹

Certainly, there was little debate as to how the disease was contracted or of syphilis’

⁷⁹ Patricia Anderson, *The Printed Image and the Transformation of Popular Culture: 1790-1860*, (Oxford, 1991), p. 2

⁸⁰ In San Francisco the spread of syphilis was associated with Chinese women. Nayan Shah, ‘Cleansing Motherhood: Hygiene and the Culture of Domesticity in San Francisco’s Chinatown’ in *Gender, Sexuality and Colonial Modernities*, Ed. Antoinette Burton, (London, 1999), pp. 19-34

⁸¹ General Alexander Arbuthnot referred to the “Virulent forms of venereal disease which prevail in India.” Minutes of Dissent by Certain Members of Council of India from the Despatch Addressed by the Secretary of State to the Government of India regarding the Contagious Diseases Act (May 1888), International Documents Collection, Parliamentary Library, Wellington, New Zealand

contagious nature. There was also an understanding of the hereditary damage syphilis could cause. The congenital form of syphilis – that passed from an infected mother to a child *in utero* – had been identified for some time. It was this form that was referred to in debates over the weakening of the ‘white race’.⁸² White British men were the apex of humanity, essentially a reflection of their superior civilization. Thus damage or dilution of this superiority was a threat to this position. There was also a full awareness that men could transfer the disease to their wives when they returned from overseas postings. Medical thought in the nineteenth century, however, assigned greatest responsibility for the transmission of syphilis to women – through intercourse or breast-feeding.⁸³ On occasion it was even thought uninfected women could spontaneously cause the disease in a man.⁸⁴ Restrictions in the metropole and India, therefore, focused on diseased women, but only those of one particular class. This class limitation rendered the legislation a futile act in terms of disease control. It served only to demonstrate action rather than effectiveness.

In contrast with syphilis, leprosy was no longer a disease present in Britain. The sixteenth century marked the end of this disease in Britain, with most lazar hospitals

⁸² The Inspector General of Hospitals, Dr Duncan MacPherson presented a memorandum to the Viceroy of India, in which he noted: “Although this loathsome malady does not kill, it renders the men a burden on the State for years, and too frequently it becomes necessary to discharge them from the service with a poison circulating in their system, which passes down to their posterity.” Series XI: Prostitution and Lock Hospitals at Military Stations, Reports on Mountain and Marine Sanitaria, (Madras, 1862) *Selections From The Records of the Madras Government*, p. 389, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

⁸³ Dr E. Lancereaux, *A Treatise on Syphilis: Historical and Practical, Vol. III*, Trans. G. Whitley, M.D., (London, 1869), p. 226

⁸⁴ Spongberg, p. 42

serving a different function at the time of the British reformation.⁸⁵ The Victorian perception of leprosy stemmed from biblical references. While controversy surrounds the exact nature of the leprosy mentioned in the Bible, crucially, the leprosy affected were excluded from the community. Medieval European culture developed this biblical foundation and understood leprosy as both a divine punishment and a benediction.⁸⁶ Those with leprosy were generally not welcome into settlements and compelled to wander between lazar houses, living off charity. Victorians assumed biblical, medieval and modern leprosy to be the same as the disease they knew. When confronted with the disease in India, the nineteenth century British person responded in a similar way to the medieval. Initially, leprosy was perceived as a disease of other less developed, that is colonial, territories; however by the 1890s the potential for re-introduction to the metropole formed a recurring theme. With the death of the white Belgian priest, Father Damien, on Moloka'i Island, Hawaii in 1889, the complacency that relegated leprosy to non-whites intensified to white anxiety over infection at home.⁸⁷ One commentator referred to the “unbridled liberty allowed to lepers in India” threatening the metropole”.⁸⁸ During the late nineteenth century there was no consensus as to the nature of leprosy's transmission method, nor any agreement as to its hereditary nature. During this time there were continuing debates centred on the question of contagious versus hereditary

⁸⁵ S.G. Browne, 'Some Aspects of the History of Leprosy: The Leprosie of Yesterday' *Section of the History of Medicine*, Vol. 68 (August, 1975), pp. 13-21

⁸⁶ Malcolm Barber, 'Lepers, Jews and Moslems: The Plot to Overthrow Christendom in 1321' *History* 66:216, (Feb 1981), pp. 1-17

⁸⁷ See also S. S. Pandya, 'The First International Leprosy Conference, Berlin 1897: The Politics of Segregation', *Historia Ciencias Saude – Manguinbos* 10:1 (2003), pp. 161-177

⁸⁸ Frederick Simms' published letter writes of the “unbridled liberty allowed to lepers in India” and how Britain was “now threatened with it at home”. Frederick Simms to Editor, *British Medical Journal*, (19th June 1889), p. 1491

causes of the disease.⁸⁹ A committee sent to investigate leprosy in India in the 1890s believed leprosy to be non-contagious, which indicates that confinement as a method of control was without the full support of all medical experts.⁹⁰ Segregation and quarantine were, regardless of competing medical ideas, popularly accepted methods of coping with imported diseases and leprosy in particular.⁹¹ There were, of course, many other diseases that threatened the metropole, however, leprosy in India generated a degree of attention that was out of proportion to the threat. Possibly because of the controversy around it, segregation of leprosy sufferers was not given *carte blanche* in India. Restrictions fell only on a specific class of afflicted.

For several reasons, leprosy and syphilis represented a failure to the British in India. These diseases evoked implications of immoral behaviour and decadence. Both diseases had an extensive history in Britain; leprosy being the earliest identified. This history contributed significantly to the image of these diseases in the Victorian popular imagination. In Medieval Europe, it was a commonly held belief that leprosy was a sexually transmitted disease, or at least a disease of sexual transgression.⁹² Immorality led to an outward sign of divine disapproval; hence the visible symptoms of the disease were a crucial factor in displaying the moral failure of the sufferer. Given the association of sexual sin and disease and the arrival of syphilis, an infection that most definitely conveyed notions of a sinful life, these two diseases were linked in the medical and

⁸⁹ One report noted that “The hereditariness of leprosy...is established beyond doubt”. British Medical Journal, (January 1867), p. 16. Others however were certain that “The disease (leprosy) is very readily propagated from one person to another by contact or cohabitation”. Dr Thomas, Journal of the House of Assembly of the Province of New Brunswick, (New Brunswick, 1845), p. 168

⁹⁰ Kakar, ‘Leprosy in British India’, pp. 215-230

⁹¹ Pandya, pp. 161-177

⁹² Mary Douglas, ‘Witchcraft and Leprosy: Two Strategies of Exclusion’ *Man*, New Series 26:4, (December 1991), pp. 723-736

religious consciousness as representing the outward physical corruption of inner weakness. Although this connection was of medieval origin, the corollary did not fade with the absence of actual leprosy sufferers from Britain. As Gilman has noted, leprosy imagery was quickly attached to syphilis.⁹³ The association of the two continued through to the Victorian era by means of literature and art.⁹⁴ The British carried this construction with them to India. It is possible this contributed to the sexualisation of the indigenous peoples. The visible presence of leprosy in India suggested to the British that Indians were sexually profligate because of the association of leprosy and sex in the European imagination. A Dr Finch, who had tended to Father Damien on Moloka'i Island in the 1880s, was convinced that leprosy was the fourth state of syphilis.⁹⁵ A person's skin colour was a further consideration as to the likelihood of contraction – darker skins being much more likely to contract the disease than a white person.⁹⁶ Europeans perceived dark skin as a marker of both leprosy and syphilis; natives were therefore cast as morally weak by virtue of their visible appearance.⁹⁷ This perception demonstrates the presumed links made between the affects of disease and the societal hierarchy. The potential for infection followed social rank, economic position and racial position – aristocratic, wealthy whites being the most unlikely sufferer, conversely poor, lower caste indigenes were the most common sufferer. In India, this was also applied to caste, with the lower castes assumed by the elite to have a higher rate of leprosy.⁹⁸ There was also a gendered

⁹³ Sander L. Gilman, *Inscribing the Other*, (London, 1991), p. 252

⁹⁴ Bryon Lee Grigsby, *Pestilence in Medieval and Early Modern Literature*, (New York, 2004), p. 76

⁹⁵ Richard Stewart, *Leper Priest of Moloka'i: The Father Damien Story*, (Honolulu, 2000), p. 209

⁹⁶ Buckingham, *Leprosy in Colonial*, p. 18

⁹⁷ Sander L. Gilman 'I'm Down on Whores: Race and Gender in Victorian London' in *Anatomy of Racism*, Ed. David Theo Goldberg, (Minneapolis, 1990), pp. 146-170

⁹⁸ H.V. Carter, 'The Pathology of Leprosy; with a note on the segregation of lepers in India', *Medico-Chirurgical Transactions*, (1873), pp. 267-284

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1988896/pdf/medcht00004-0337.pdf>.

component to leprosy, which will be discussed later. Europeans who contracted syphilis or leprosy in India were unwanted examples of fallibility, demonstrating themselves to be on the same level as locals. To an extent, the British hierarchy accepted the lower social position of the enlisted of the army. These men were generally from lower classes in the metropole, which in Victorian elite thinking was associated with disorder, disease and immorality.⁹⁹ Too many diseased soldiers, however, corresponded to a diminution of martial superiority. To combat the appearance of weakness, colonial authority sought to conceal any flaw in its own character whilst attempting to ameliorate the supposed faults of the colonised.

Added to the moral failure associated with the person affected by the disease was the fact that both leprosy and syphilis signified a failure of Western medical practices. In the latter half of the nineteenth century science was exploited to justify superiority, especially of white male culture.¹⁰⁰ If the army represented the incarnation of British imperial might, then British science and technology was the incarnation of imperial intellectual superiority. European scientific advances contributed to the sense of mandate that the British espoused in India. Inoculation programmes, western style medical schools and pharmacological knowledge all acted as devices to establish British scientific and medical concepts as superior to the indigenous.¹⁰¹ Throughout the nineteenth century, the British medical profession had slowly enhanced its position as holders of special knowledge and training. Insecurity around this recently gained social position added to

⁹⁹ Mort, *Dangerous Sexualities*, p. 37

¹⁰⁰ Joanna De Groot, ‘“Sex and Race”: The Construction of Language and Image in the Nineteenth Century’ in *Sexuality and Subordination: Interdisciplinary Studies of Gender in the Nineteenth Century*, Eds. Susan Mendus and Jane Rendall, (London, 1989), pp. 89-128

¹⁰¹ Arnold, *Colonizing the Body*, p. 43

the necessity to reinforce the abilities of Western doctors as superior to their indigenous equivalents. Vaughan has argued that medical power/knowledge were not central to colonial control;¹⁰² however, it is possible to argue that it was a key part of imperial self-image. Medical and scientific professionals formed a significant part of the British middle-class elite in India and as such form a significant element in the perceptions of the colonisers. Arnold stated: “The medical profession had a profound influence upon the way in which the colonial power investigated, understood, and ultimately attempted to manage indigenous society.”¹⁰³ Visibly untreatable infections therefore undermined the power of scientific medical treatment and its challenge to indigenous systems. Despite many varied efforts, Western medicine was unable to combat successfully either leprosy or syphilis.¹⁰⁴ In effect, leprosy and syphilis challenged western authority and its claims to superior knowledge.

Superiority, martial, technological and moral, formed a cornerstone of Britain’s imperial view of itself and its justification of empire – the concept of the civilizing mission. Syphilis and leprosy, however, threatened this concept too. During the nineteenth century there was a popular idea of a Darwinian arc to societies, that is a perfectly evolved one. This theory had placed Europe – and more especially for the British, Britain – at the pinnacle. As noted above, civilization required industrialization,

¹⁰² Vaughan, *Curing Their Ills*, p. 10

¹⁰³ Arnold, *Colonizing the Body*, p. 291

¹⁰⁴ Before the introduction of a successful drug treatment in the twentieth century, the Gurjon Oil and, more especially, Chaulmoogra Oil – both Ayurvedic treatments derived from indigenous trees – were the treatments of choice for leprosy. See for example: ‘Report on the Treatment of Leprosy, with Gurjon Oil and Other Remedies in Hospitals in the Madras Presidency’ *Selections from the Records of the Madras Government*, (Madras, 1876), *Selections from the Records of the Government of India*, University of Canterbury Library (microfilm)

capitalism and a well established hierarchy, each level of which maintained its own sphere.¹⁰⁵ The British judged other societies by comparison to its own exemplar and it was this that colonial authorities sought to export to the colonies. Queen Victoria wished to support the “peaceful industry of India, to promote works of public utility and improvement”.¹⁰⁶ Effectively, there was a desire to recreate an idealised British civilisation in the sub-continent. However, along a spectrum India was only halfway to achieving this, earning Indian society the label of ‘medieval’. By contrast sub-Saharan African societies were considered very much lower.¹⁰⁷ The presence of leprosy, a disease that had largely disappeared from modern Britain, but had been present in the middle ages, evidenced the unevolved nature of Indian society. However, lesser societies could evolve and with civilizing influence of the British, the colonisers believed Indian society could be improved. Syphilis however, was an indication of the failure of the civilizing mission from the coloniser’s perspective. The most common example of ‘Britishness’ in India was the soldier; he was the visible embodiment of the nation.¹⁰⁸ His succumbing to the temptation of exotic women and becoming infected as a result highlighted the underlying fiction of British superiority. A self-imposed mandate, which involved the civilizing of all the peoples of the empire, demanded the elimination of such diseases. These diseases also highlighted the otherness of the colonies and were part of the danger of the exotic that needed to be conquered and ordered. However, the inability of the modern society to rid the less developed of leprosy and syphilis undermined the civilizing mission by demonstrating its fallibility. The only suitable remedy therefore became one

¹⁰⁵ Hall, ‘Of Gender and Empire’, pp. 46-76

¹⁰⁶ Bernard S. Cohn, *Anthropologist amongst Historians and other Essays*, (Oxford, 1987), p. 633

¹⁰⁷ D. George Joseph, “‘Essentially Christian, Eminently Philanthropic’: The Mission to Lepers in British India’ *Historia Ciencias Saude – Manguinhos*, 10:1, (2003), pp. 247-275

¹⁰⁸ Myna Truham, *Women of the Regiment: Marriage and the Victorian Army*, (Cambridge, 1984), p. 201

of removal – the concealment of visible sufferers. Colonial authority defined, separated and removed from the public gaze that which undermined the achievement of a civilized society in India.

Of the two diseases, syphilis had the greater physical presence in the metropole, permeating Victorian culture and psychology. In India, it also directly affected military manpower. Consequently, it was the subject of legislative efforts much earlier than leprosy. The unassuming name of the law, the Contagious Diseases Act, may imply application to any transmittable infection, however, this legislation referred specifically to venereal diseases. Moreover these diseases were on the whole, indistinguishable by the technology of this period in their early stages. During the nineteenth century, there was a common belief in Britain that the levels of syphilis and other venereal infections were increasing within the British population.¹⁰⁹ However recent studies of the actual evidence do not support this and rates of infection may have been decreasing by the 1860s.¹¹⁰ Given this mistaken view of disease levels and the effect on army personnel, venereal disease in general and syphilis in particular were something of a medical obsession in Europe during the nineteenth century. Many civilian and military doctors wrote on the dangers that these diseases posed to the population.¹¹¹ Much of the responsibility for maintaining law and order in colonial territories fell to the army. Hence, the levels of infection found in the military forces were of considerable concern for the British authority in India, and elsewhere. Consequently initial legislation targeted

¹⁰⁹ George R. Dartnell, Inspector-General Hospitals, H.P., *British Medical Journal*, (April, 1860), pp. 317-319

¹¹⁰ Paul McHugh, *Prostitution and Victorian Social Reform*, (London, 1980) p. 260

¹¹¹ Levine, *Prostitution, Race and Politics*, p. 41

military centres of operation followed later by large towns and cities as secondary sites. Throughout the British Empire, as well as other European territories, stopping the venereal epidemic became important. As a result, the phenomenon of Contagious Diseases legislation was not limited to India. The earliest imperial legislation was in Hong Kong in 1857 and was instigated by the British Navy.¹¹² This was followed by similar acts in Malta, Britain, India, Canada, Australia and numerous other regions of the empire. Known collectively as the Contagious Diseases Acts, these laws spanned the British Empire.¹¹³ Despite localized differences in the specifics of the acts all without exception targeted as the primary cause of syphilis local prostitutes servicing a white clientele. However as an analysis of the Cantonment Regulations – the rules managing residential areas assigned to the military - and the Contagious Diseases Act in India will demonstrate there was little relationship between the realities of disease control and the focus of the legislation.

The Contagious Diseases Act in India was based directly on the version passed in the British parliament and applicable in military areas in the metropole. This act, in turn, was based on a French system of regulation.¹¹⁴ The very title of the Act had been selected in order to disguise its main topic. In 1857, the British government had passed a Contagious Diseases (Animals) Act, dealing with the treatment of infectious animals.¹¹⁵ As can be seen the titles of the two acts are practically identical. The hope, presumably,

¹¹² Levine, *Prostitution, Race and Politics*, p. 40

¹¹³ Starting in Hong Kong in 1857, versions of the Act spread back to the metropole and then out to the naval ports and colonies. The evolution and devolution of the various acts is covered extensively in Philippa Levine, see chapter 'Law, Gender and Medicine' in *Prostitution, Race & Politics: Policing Venereal Disease in the British Empire*, (London, 2003)

¹¹⁴ Elizabeth B van Heyningen, 'The Social Evil in the Cape Colony, 1868 – 1900, Prostitution and the Contagious Diseases Act' *Journal of Southern African Studies*, 10:2, (Apr. 1984), pp. 170-197

¹¹⁵ McHugh, *Prostitution*, p. 37

was to avoid undesirable debate as most members of parliament would assume it was just another veterinary statute. It is possible to argue that the prostitutes, who were the focus of the act, were assumed to be as lacking in rights as the diseased cattle which were the focus of the earlier act. Certainly neither group was likely to have a voice in the construction of the legislation. The Victorian characterisation of acceptable womanhood was one of passive, asexual submission.¹¹⁶ Therefore the presumption of parliament to insist on the treatment of diseased women, with or without permission was not out of character. This was similar to the way that colonial authority introduced legislation to its territories with the idea of knowing what was best for the local population. The Act was introduced to a parliamentary session late at night and with little comment.¹¹⁷ The passing of the law itself was completed as quietly as possible.

Legislative controls did not aim to curb all sufferers. The treatment and control of males with venereal diseases was not a requirement in any of the government efforts. The Cantonment Regulations and the Contagious Diseases Acts specified women for confinement. Despite awareness of syphilis afflicting both sexes - statistics gathered in annual lock hospital reports by the surgeon general compared rates of disease between men and women - legislation and regulation sought only to control women.¹¹⁸ Women were characterised as actively spreading the disease to men, who suffered more severely than females.¹¹⁹ Not only the medical world adopted this depiction of the diseased

¹¹⁶ Mort, *Dangerous Sexualities*, p.37

¹¹⁷ McHugh, *Prostitution*, p. 37

¹¹⁸ Rates of venereal disease by regiment, as well as the numbers of women treated in the lock hospitals are recorded in the annual report. See for example 'Annual Report of the Lock Hospitals of the Madras Presidency 1874', *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

¹¹⁹ Gilman, *Inscribing*, p. 250

female into its psyche. European culture characterised syphilis as feminine death. Poetry, art and literature all incorporated images of the syphilitic. The culture of this period represented syphilis as a “feminized form of waiting death – a Nietzschean salivating witch”.¹²⁰ In British literature, the ‘fallen woman’ was a consistent character in novels, plays and poems and the metropolitan legislation targeted only women as the polluters of men. As Spongberg stated “Women came to be perceived as a health problem and was viewed in much the same manner as a cesspool or a badly planned sewer”.¹²¹ Large populations of males, such as the army and the burgeoning urban factory workforce, were seen as potential victims. The legislation promoted to control syphilis not only attempted to reduce the impact of infection on military power and economic assets, which the manpower resource was, it also attempted to curb socially unacceptable behaviour. As De Groot has noted, throughout the nineteenth century the East was characterised in feminine/sensual terms as in need of domination and control.¹²² The feminine east and the characterisation of syphilis as female death combined in colonial territories. Syphilis became a matter of gender and race in the British Empire. Colonial authority would need to control this disease to maintain a dominant position, white superiority and masculine authority.

In the case of leprosy, it was not the number of sufferers that prompted the colonial government of India to instigate legislation directed against those who contracted the disease. The Lepers Act of 1898, although practically falling into the twentieth century, was very much a part of nineteenth century debate and not just one focused on British

¹²⁰ Gilman, *Inscribing*, p. 115

¹²¹ Spongberg, p. 36

¹²² Joanna de Groot “Sex” and “Race”, p. 89-128

India. Norway, a European outpost of the disease passed containment legislation in 1877 and 1885.¹²³ The Royal College of Physicians' *Report on Leprosy* published in 1867 gathered information from around the world.¹²⁴ It is possible to argue that one of the reasons for the increased interest in leprosy in India was due to the request for advice by the colonial secretary in the West Indies in 1862 regarding the disease amongst black workers.¹²⁵ This interest prompted an Empire-wide census. Government and medical staff across the British Empire were sharing information and ideas about the disease. Before the successful introduction of the Lepers Act in 1898 in India, there had been attempts to introduce legislation to govern leprosy sufferers for more than a decade.¹²⁶ Prior to this, there had been numerous commissions, reports and reviews investigating leprosy throughout India and the Empire.¹²⁷ The Madras Presidency produced a report in 1876 looking at the treatment of leprosy with gurjun oil and other remedies, thereby disseminating native remedies world-wide.¹²⁸ While the focus here is India, the debate around the disease and its treatment was neither isolated nor contained in a vacuum. Leprosy in India influenced international ideas and was in turn influenced by international ideas.

¹²³ Abraham Meima *et al*, 'Disappearance of Leprosy from Norway: An Exploration of Critical Factors Using an Epidemiological Modelling Approach' *International Journal of Epidemiology*, 3:1, (2002), pp. 991-1000

¹²⁴ The Royal College of Physicians' 'Report on Leprosy', (1867) in *The British and Foreign Medico Chirurgical Review*, (January 1867), pp.360-375

¹²⁵ Edmond, *Leprosy and Empire*, p. 51

¹²⁶ Buckingham, *Leprosy in Colonial South India*, (Basingstoke, 2002), p. 157

¹²⁷ Buckingham, 'Chapter 1, Concepts of Leprosy', *Leprosy*, pp. 7-35

¹²⁸ 'Report on the Treatment of Leprosy, with Gurjon Oil and Other Remedies in Hospitals in the Madras Presidency' *Selections from the Records of the Madras Government*, (Madras, 1876), Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

Cultural and political influences starting in the middle of the nineteenth century engendered the movement towards legislation for leprosy. The European conception of leprosy initially derived from biblical texts. Leviticus offered a definition of the disease, differentiating between 'clean' and 'unclean', as well as the exclusion of sufferers by putting the infectious 'outside the camp'.¹²⁹ Added to this there were the gospels, which included Jesus ministering to lepers.¹³⁰ Leprosy was both a marker of sin and a disease worthy of charity. Modern scholars have questioned the accuracy of the term leprosy for the diseases described in the Bible; nevertheless this was a primary text for the basis of European understanding of the disease. With the appearance of the disease in Europe in the middle ages, the Vatican adopted and propounded the Levitical measures for leprosy.¹³¹ For the medieval European leprosy sufferer the result was exclusion, persecution and demarcation as an outsider; a physically marked other. At one point being a 'leper' carried a death sentence.¹³² Separation and isolation were the norm. However, there was also the tradition of ministering to leprosy sufferers.¹³³ The establishment of lazar houses grew during the Middle Ages and tending to the patients, by people such as St Francis of Assisi, was interpreted as a sign of particular devotion.¹³⁴ Leprosy was associated with sins of both the flesh and the spirit. It was characterised as a sexual disease and also a punishment for heresy.¹³⁵ The later Middle Ages, when the disease was in fact becoming less prevalent in Europe, saw sufferers described as

¹²⁹ Leviticus, Chapters 13-14 deal entirely with the ritual position of the leprosy sufferer.

¹³⁰ Gospel of St Mark, Chapter 1, Verses 40-45; Gospel of St Luke, Chapter 17, Verses 11-19

¹³¹ Malcolm Barber, 'Lepers, Jews and Moslems: the Plot to Overthrow Christendom in 1321', *History*, 66:216, Feb 1981 p. 1-17

¹³² *Ibid.*

¹³³ C. Warren Hollister and Judith M. Bennett, *Medieval Europe: A Short History*, 9th Edition, (New York, 2002), p. 203

¹³⁴ Hollister and Bennett, *Medieval Europe*, p. 239

¹³⁵ R. I. Moore, *The Formation of a Persecuting Society*, (Oxford, 1987), p. 62

libidinous, diseased threats to society and as such stigmatised as objects of fear and superstition.¹³⁶ This binal characterisation of leprosy continued through to nineteenth century Europe. Victorian Europeans were disgusted and moved to charity by this disease, just as their counterparts in the Middle Ages had been.

Several factors combined to raise the spectre of leprosy in the colonial imagination and during the late 1800s expand in disproportionate importance to its occurrence. Crucially, leprosy became visible to the British with their greater insertion into India. This renewed visibility was imbued with the characterisations of leprosy that already existed in the metropole. Europeans, in particular the British, believed that leprosy was no longer a disease of their world. Gussow has argued that there was no continuous tradition of stigmatization of leprosy and that the disease was re-stigmatized in the nineteenth century.¹³⁷ Literature, however, continued from the medieval through to the modern age to exploit the illness as a continuing metaphor.¹³⁸ It is much more likely, therefore, that when obvious visible examples appeared, as they did in British India, these well-embedded cultural symbols adapted and revived an old fear. Concepts such as confinement, exclusion, miasmatic causation and moral transgression are all elements of the medieval/biblical imagery that leprosy conveyed into the Victorian period. This imagery contributed to the late nineteenth century developments such as sanitation, scientific theories of inherited traits and as noted above, incorporated ideas of race, gender and religious fervour.

¹³⁶ Moore, p. 79

¹³⁷ Gussow, *Leprosy, Racism and Public Health*, p. 6

¹³⁸ Brody, p. 197

Although the British metropole saw very little leprosy in the nineteenth century, the disease was still present in pockets; the most notable of these being in Norway. It was in Norway that Dr Hansen would identify the mycobacterium that caused leprosy and thereby gave the disease its alternative name – Hansen’s disease. Norway followed the medieval traditions of isolation and exclusion. Much earlier than in India, there was legislation in Norway for the containment of leprosy sufferers. An 1877 law required withdrawal into the home or hospitalisation. By 1885 this was intensified to forcible hospitalisation for those not restricted to the home.¹³⁹ Those afflicted were forbidden to marry and, in some places, there were by-laws prohibiting people with leprosy from residing in the cities.¹⁴⁰ As with the British legislation in India societal position played a part in who was contained. Wealthier leprosy sufferers were able to afford home exclusion, which was out of the reach of the poorer members of society. Norway did not successfully confine all of its diseased.¹⁴¹ Isolation was the only option open to nineteenth century society and as a form of limiting any possible spread was a socially acceptable choice. However, the segregation was still restricted to certain strata of society. Thus, just as in India, Norwegian legislation was not a means of disease control or a public health response, but a form of social control.

The civilizing mission of the British included not just the secular, but also a spiritual element. Although not the compelling force behind government policy, Christian morality influenced government officials as well as missionaries. In India, where the vast majority of the population was Hindu, there were efforts to avoid too obvious a Christian

¹³⁹ Peter Richards, *The Medieval Leper and his Northern Heirs*, (New York, 1995), p. 93

¹⁴⁰ Richards, p. 50

¹⁴¹ Richards, p. 87

influence, often causing tension between government and missionaries. Nevertheless evangelical Christianity shaped the colonisers themselves.¹⁴² From the 1880s onwards, the character of Victorian religious beliefs, with the renewed interest in evangelism, contributed to the heightened public focus on leprosy. During the nineteenth-century religious attendance and membership of religiously motivated groups exploded in the metropole. However, the first seeds of this can be seen in the growing influence of earlier groups such as the Clapham Sect, with its focus on the anti-slavery campaign in the late eighteenth, early nineteenth century. As Catherine Hall has convincingly argued, however, anti-slavery was not the only focus of Anglican evangelicals. Also of concern and of no less importance, was the transformation of British society. “The Evangelical emphasis on the creation of a new life-style, a new ethic, provided the framework for the emergence of the Victorian bourgeoisie.”¹⁴³ This ‘first wave’ of evangelism receded during the first years of Queen Victoria’s reign. Religion then reasserted itself in the 1870s with a stronger significance attached to the visible performance of duty - it was this active, ‘muscular’, form of Christianity which achieved prominence in the Christian leprosy missions such as the Mission to the Lepers in India and the East, founded in 1874. One’s duty was both to the improvement of the individual and society. Muscular Christianity influenced all aspects of Victorian society and its self-representation, including the re-conception of the military as the physical arm of a morally justified and divinely authorised civilization. The emphasis of societal behaviour for the growing middle-classes turned to the living of a ‘Christian life’. Victorian society had developed

¹⁴² Andrew Porter, ‘An Overview 1700-1914’ in *Missions and Empires*, Ed. Norman Etherington, (Oxford, 2005), pp. 40-63

¹⁴³ Catherine Hall, ‘Early Formation of Victorian Domestic Ideology’ *Fit Work for Women*, Ed. Sandra Burman, (London, 1979) pp. 15-32

its own neo-puritans.¹⁴⁴ Not only did one have to be good, one had to be seen to be good. Christianity and Christian motives therefore grew to be one of the major factors influencing British society during the nineteenth century and consequently the behaviour of the British in India.

It was during the nineteenth century that the work of missionaries in the colonies, as well as the domestic sphere, experienced a dramatic increase. At this time it is estimated more than one sixth of the British population considered themselves to be evangelicals.¹⁴⁵ Not all sections of society, however, considered missionaries beneficial, some saw their preaching as subversive and largely responsible for slave uprisings in the West Indies.¹⁴⁶ Possibly because of this, the East India Company was reluctant to allow missionaries into India and campaigning by the Clapham Sect to gain entry was initially unsuccessful.¹⁴⁷ However, with the renewal of the East Indies Company's charter in 1813, official restrictions against missionaries were removed.¹⁴⁸ In 1839, the Reverend Alexander Duff wrote of the importance of Christian missionary work describing the "spiritual conquest of 'the world' of 'all nations' as the 'supreme function'".¹⁴⁹ Duff writing regarding the Church of Scotland's missionary work in India went on to note that the decline of these efforts would result in the decline of the Church itself.¹⁵⁰ Following the events of 1857,

¹⁴⁴ Porter, 'An Overview', pp. 40-63

¹⁴⁵ Boyd Hilton, *The Age of Atonement: The Influence of Evangelicalism on Social and Economic Thought, 1795-1865*, (Oxford, 1988), p. 26

¹⁴⁶ Hall, *Civilizing Subjects*, p. 11

¹⁴⁷ Michael Mann "'Torchbearers Upon the Path of Progress': Britain's Ideology of a "Moral and Material Progress" in India. An Introductory Essay' in *Colonialism as Civilizing Mission: Ideology in British India*, Ed. Harald Fischer-Tine and Michael Mann, (London, 2004), pp. 1-28

¹⁴⁸ Robert Eric Frykenberg, *Christianity in India: From Beginnings to the Present*, (Oxford, 2008), p. 261

¹⁴⁹ Reverend Alexander Duff, *India and India Missions: Including Sketches of the Gigantic System of Hinduism Both in Theory and Practice*, (Delhi, 1988, originally published Edinburgh, 1839), p. 498

¹⁵⁰ Duff, p. 499

the British victory was represented as a Christian victory over heathenism. The suppression of the rebellion and the sacrifice of men such as Sir Henry Havelock were constructed as the superiority of Christian values over other religions.¹⁵¹ This further enhanced the status of muscular Christians, of whom Havelock was one. Middle-class elements of Victorian society established its identity as superior by right of its physical courage, moral rectitude and militant Christian faith. In India, bourgeois British society's desire to improve the lot of the indigenous population had initially focused on education.¹⁵² This expanded in the latter half of the nineteenth century to include the provision of medical attention.

Leprosy, which was biblically evocative of the ministries of Jesus, was ideally suited as a focus for this outpouring of Christian charity, missionary fervour and imperialism. The gospels of both Mark and Luke contain references to Jesus showing compassion for lepers.¹⁵³ These passages discuss ideas of both healing and forgiveness. For the evangelical missionaries of the Victorian period, this created a divine precedent. Not only was the treatment of leprosy sufferers a very Christian act, it also enabled true Christian to express the intensity of their belief and ensure that that belief was visible. Further, the Gospel of Luke emphasised the conversion of the foreigner. In the story of the ten lepers healed by Jesus, the individual who demonstrated his gratitude, and by implication his acceptance of Christianity, was a Samaritan; that is a foreign non-

¹⁵¹ Edward M. Spiers, *The Late Victorian Army, 1868-1902*, (Manchester, 1992), p. 182

¹⁵² Andrew F Walls, 'The Missionary Movement: A Lay Fiefdom?' in *The Rise of the Laity in Evangelical Protestantism*, Ed. Deryck W. Lovegrove, (London, 2002), pp. 167-186

¹⁵³ Gospels of St Mark, Chapter 1 and St Luke, Chapter 17

believer.¹⁵⁴ This gave missionaries, further inspiration for the link between healing and conversion. While the achievement of a cure may have been beyond the abilities of the missionaries there was still the recompense that souls could be saved.¹⁵⁵ When Father Damien died in 1889, his story was quickly converted into a morality tale for consumption by a European audience; thereby feeding into the re-imaging of leprosy as a suitable outlet for humanitarian efforts.¹⁵⁶ There were some inter-denominational tensions, possibly due to Protestant ministers' jealousy over the lack of attention paid to their previously existing efforts at ministering to the residents of Moloka'i.¹⁵⁷ However these were not significant enough to invalidate his stature and he provided a faultless example of the Christian martyr and moves to commence his beatification were rapid.¹⁵⁸ Father Damien's work encompassed the ethos of the Victorian evangelical, which advocated "Active benevolence, which attempted to demonstrate the spirit of Christ by helping other people who were in need."¹⁵⁹ Leprosy sufferers, both in Hawaii and India, were certainly seen as falling into this category. The earliest European writings on India marked leprosy sufferers as poor; those seen begging.¹⁶⁰ This concept did not alter during the later nineteenth century and indeed may have further enhanced the appeal of leprosy charity work as treating both the poor and the afflicted in one package. Leprosy was embodied in a colonially created construction of Christian values and colonial

¹⁵⁴ Gospel of St Luke, Chapter 17, Verses 11-19

¹⁵⁵ A. Donald Miller, *An Inn Called Welcome: The Story of the Mission to Lepers 1874-1917*, (London, 1965), p. 8

¹⁵⁶ Charles Stoddard a journalist and academic was one of the men responsible for the renown of the Father Damien story, relating it to Robert Louis Stevenson in 1878. Richard Stewart, *Leper Priest of Moloka'i: The Father Damien Story*, (Honolulu, 2000), p. 375

¹⁵⁷ Gavan Daws, *Holy Man: Father Damien of Molokai*, (Honolulu, 1984), p. 61

¹⁵⁸ Father Damien was beatified in 1995 and canonized in 2009. Richard Stewart, *Leper Priest of Moloka'i: The Father Damien Story*, (Honolulu, 2000), p. 391; www.fatherdamien.com

¹⁵⁹ Kathleen Heasman, *Evangelicals in Action: An Appraisal of Their Social Work in the Victorian Era*, (London, 1962), p. 28

¹⁶⁰ Buckingham, *Leprosy*, p. 18

improvement of exotic societies. The constructed leprosy sufferer was therefore a poor foreign heathen, who would not survive without western support. Colonial re-imagining of the leprosy sufferer has continued to influence western thinking.

The imagined significance of leprosy and syphilis deeply influenced the construction of legislation and the treatment of those afflicted with these diseases. Leprosy and syphilis were both diseases that had symbolic weight in Victorian British society. It was, in part, the nature of the diseases that contributed to the significance, in particular the highly visible symptoms of the late stages. Historically, European sufferers were isolated from their communities and stigmatised by their disease. The association with profligacy and immorality were features of both leprosy and syphilis and this was carried through to colonial territories. For the British in India, leprosy and syphilis also carried the perception of threat and failure; failure of British superiority, threat to authority and the metropole itself. However, ideas around race, class and gender also contributed to the reading of leprosy and syphilis in India. Essentially the metaphorical interpretation of leprosy and syphilis engendered a stronger response than the biological implications of these diseases.

Section Two - Law as a Cultural Marker:

Initially based on European models, the introduction of the Contagious Diseases Acts and the Lepers Act into India profoundly affected their construction. More than thirty years separates the introduction of the Contagious Diseases Acts in 1864 and the Lepers Act in 1898, however, they should be considered a result of the same milieu. Consequently, an examination of these two pieces of legislation highlights the British perception of its own society and its understanding of other cultures. A comparison of the acts and the Victorian conceptions of morality, class, sex, race and the authority that provoked them offer a prism through which to view the society that produced them. These acts were not uncontested and the nature of the opposition gives further insights into the nature of the legislation. A thorough investigation of the two laws reveals the motivations of the framers and assumptions that were made based on the cultural construction of these disease. Contained within both acts were overt and implicit characterisations of the coloniser and the colonised, as well as the categorisation of the population that was a feature of colonial authority. Additionally an examination of the success of the two statutes in achieving their goals further demonstrates the tensions that existed between legislation and its application. Although the legislation for both diseases clearly noted leprosy and syphilis as two different entities, colonisers imbued with European society's cultural and moral paradigms framed these acts.

The leprosy legislation, which was eventually introduced into British India, was not as widespread in the Empire, unlike the venereal disease acts. Although there was leprosy

present in a number of places throughout British possessions, including the West Indies and Fiji, this had not translated into extensive statutes.¹ There are several factors that explain the limited amount of legislation. Firstly, the numbers of people, who contracted leprosy, as noted previously, were always relatively low as well. Secondly, there was the continuing controversy over the means of transmission of leprosy. Finally, the official response to leprosy, and whom it infected, had a decidedly racial nature. The government of the USA, for example, was concerned over leprosy among Hawaiian Islanders, but did little regarding the continental Norwegians immigrants with this disease.² Syphilis was, however, a significant numerical threat and the European population was directly threatened by this disease. Contagious Disease legislation or derivatives thereof, were present in every colonial possession from India to New Zealand.³ The specifics differed slightly from place to place, but in each case the law focused on the control of female prostitutes as the main vector of infection. And whilst leprosy concerned offshore colonial territories, specifically those marked as ‘uncivilized’, syphilis threatened the seat of power. In British India, venereal disease could be interpreted as a direct risk to colonial dominance. The Cantonment Regulations introduced in India initially mirrored the metropolitan Contagious Diseases Act of 1864; however, this quickly changed and expanded to include large urban centres. It is arguable that the ability to introduce a law such as the Contagious Diseases Acts into the colony, a law which allowed for the incarceration of incurable disease sufferers,

¹ A consequence of enquiry into Windward Islands and Royal College of Physicians’ Report was removal of existing legislation – in the 1860s. The Royal College of Physicians’ ‘Report on Leprosy’, (1867) in *The British and Foreign Medico Chirurgical Review*, (January 1867), pp.360-375

² Pandya, pp. 161-177; See also Gussow, *Leprosy, Racism and Public Health*

³ Levine, *Prostitution, Race and Politics*, p. 15

encouraged the use of similar confining legislation for other issues. It was not only the Lepers Act and the Contagious Diseases Acts which targeted fringe groups of society within India, other acts, such as the Criminal Tribes Act of 1871, follow a comparable pattern, where a biological factor – hereditary or contracted – was sufficient for arrest.⁴

The Contagious Diseases Act and the Lepers Act concentrated on confinement of those considered most likely to spread these infections. The laws introduced to tackle the problem of leprosy and syphilis were a part of the wider British efforts to rationalise and manage Indian society through codification and regulation. The implication of this was that the existing system was chaotic and uncontrolled. However, the indigenous population had a multitude of religion-based laws, as well as medical systems, with which to define and control disease.⁵ Certainly leprosy, which had been present in the continent for centuries, was well-known; Hindu and Muslim law recognised degrees of infection ruling according to the level of ulceration.⁶ Syphilis was a more recent arrival to the sub-continent and may well have arrived only with Europeans in the sixteenth century.⁷ It was, however, by the nineteenth century well-established in all the urban centres. Cultural mores already controlled the societal position of women and sex workers, effectively performing a similar exclusionary function as the Contagious Diseases Act would. In the case of leprosy and syphilis, the British legislation did not take into account the indigenous rulings on these areas and introduced a primarily

⁴ Anand A. Yang, 'Dangerous Castes and Tribes: The Criminal Tribes Act and the Magahiya Doms of North East India' in *Crime and Criminality in British India*, ed. Anand A. Yang, (Tucson, 1985), pp. 108-127

⁵ J. Duncan M. Derrett, *Religion, Law and the State in India*, (Delhi, 1999), p. 319

⁶ Buckingham, 'Morbid Mark', pp. 57-80

⁷ Crosby, p. 151

European inspired method of managing these diseases. In other instances, Europeans had attempted to streamline or incorporate elements of local law, although this generally meant imposing consistency that had not previously existed by reifying certain principles and removing the traditional flexibility in interpretation.⁸ Neither were these diseases epidemic, which could possibly justify extreme measures that overrode local sensibilities, as was the case with plague.⁹ Therefore the motivation behind the establishment of these acts must lie in the area of social control and the assertion of colonial power.

The Lepers Act passed into law in India in a form defined by preceding debate, having undergone any required changes. This was not the case with the Contagious Diseases Act. In India, control was first contained within the army regulations governing the military cantonments. Subsequently, the India Contagious Diseases Act 1868, extended military regulations to the civilian populations of large towns and cities in 1868.¹⁰ The form of the acts and those primarily targeted by it offer greater insight into the cultural mores of nineteenth century British society than into the operating procedures of contemporary public health. The legislation engendered a highly visible 'carrier' that fitted with cultural assumptions, while not offending local opinion. The confinement of the visible would also make a visible display of government authority. An examination of these pieces of legislation and the nineteenth century understanding of the diseases demonstrates Victorian concepts of morality, class, gender and how these contributed to

⁸ De Souza, pp. 61-74

⁹ An outbreak of plague in the 1890s saw measures including mandatory hospitalization, search parties, the halting of pilgrim traffic and disinfection of houses, which caused attacks and riots. Ira Klein, 'Plague, Policy and Unrest in British India', *Modern Asian Studies*, Vol.22:4, (1988), pp. 723-755

¹⁰ Cantonment Regulations framed under Act XXII of 1864 and Act III of 1880 (Office of Quartermaster General in India, Simla, 1887) (Government Printing, Calcutta, 1887) L\MIL\17\5\1828, Oriental and India Office Collections.

the construction of a visible archetype, whose containment then served to witness colonial government's successful social control.

The Contagious Diseases Act of 1868 was a product of the civilian government of British India, although the influence of the military in this cannot be denied. Its stated purpose was the prevention of certain diseases – defined in the Act as venereal diseases, including gonorrhoea. The Act dealt specifically with women who might have venereal disease. That the woman was definitely a prostitute was not a requirement of the legislation merely that information had been received that she was infected and may be working as a prostitute. Nor were the terms prostitute or prostitution defined anywhere. The management of prostitutes was identical in the civilian Contagious Diseases Acts 1868 to that in the military Cantonment Regulations of 1864. This military act regulated and managed military and non-military life within army bases, including the behaviour of non-military personal, such as prostitutes. The extensive rules regulated everything from legal jurisdiction to the sale of spirituous liquors. The specific portion related to venereal disease was located in Section XIX of the Act, which dealt with what the regulations could rule on. This included a range of varying areas such as the expenditure of cantonment funds, registration of births and deaths and the maintenance of cesspools and rubbish dumps. The clause that dealt with venereal disease referred to “Inspecting and controlling of houses of ill-fame and for preventing the spread of venereal disease.”¹¹ However, the main focus of this clause was in fact the control of prostitution and not the lock hospitals or the treatment for syphilis sufferers. The members of a special

¹¹ Clause 7, Section XIX, Cantonment Regulations

committee of seven men, headed by Lieutenant Colonel S.F. MacMullen, were responsible for the detailed clarification of all the rules and regulations set out in the Act. According to Special Committee's Exposition of the Lock Hospitals Rules, contained within the Cantonment Regulations, there were four areas about which they all agreed. The first of these was the "registration of all public prostitutes".¹² In the Exposition of The Cantonment Regulations the Bengal Sanitary Commission was quoted as stating that the "People of every town and district are directly interested in the preservation of the health of the troops by whom they are protected".¹³ The appearance of the Cantonment Regulations prior to the civilian legislation makes it clear that the control of venereal disease was closely related to military necessity. Given the high percentage of hospitalisations for soldiers that were attributed to syphilis, there was little option except to make an effort to control the rates of V.D. amongst the men.

The prostitutes and the diseases which they carried represented a threat to the colonial authorities of India; the primary threat being to the military. Britain's largest standing army was located in India.¹⁴ The maintenance of British Authority in the region made it crucial that the manpower of the military remain at peak fitness. "The protection of the health and efficiency of the British garrison as a paramount duty of the ruling power" was noted in one despatch sent in 1888 from the Secretary of State for India to the Governor

¹² *Special Committee's Exposition of the Lock Hospital Rules* from the Committee appointed for framing Rules to be passed under Section 19 of Cantonment Regulations Act XXII of 1864 to the Government of India Military Department, 1865, (Calcutta, 1887) L\MIL\17\5\1828, Oriental and India Office Collections, British Library

¹³ *Special Committee's Exposition of the Lock Hospital Rules*, p. 96

¹⁴ Edward M. Spiers, *The Late Victorian Army 1868-1902*, (Manchester, 1992), p. 274

General of India.¹⁵ However, logistically, it was impossible for the British government to man every garrison with white troops from the metropole. Therefore, necessity required the recruitment of indigenous troops. With memories of the Indian Mutiny still fresh however, the white troops needed to maintain their perceived superiority over the Indian troops. This was made difficult by the susceptibility of the British troops to tropical disease. Many of the diseases, such as cholera, malaria and small pox, western medicine, to a degree, tackled successfully. Syphilis, which produced the highest levels of morbidity amongst European troops, was not.¹⁶ Of more concern, was a comparison of European and native infection rates, which showed that the native soldier had a considerably lower level of syphilis.¹⁷ It would have been impossible to render invisible all the syphilis sufferers in the army, given the particularly high levels of infection. In one estimate up to one third of British army personnel were infected with the disease.¹⁸ It would have been completely impractical to isolate that many troops or to constantly replace them from the metropole. However, the presence of this number of diseased troops potentially undermined the superiority of the white coloniser. The characterisation of the disease thus shifted to incorporate imagined colonial fears such as the possibility that native women were deliberately infecting British soldiers with syphilis. The disease left soldiers with 'constitutions polluted with a destructive poison, which so many carry to their grave; too often contaminating with their loathsome disease those whom they

¹⁵ Despatch from the Secretary of State for India in Council to the Indian Government with respect to the Contagious Diseases Acts and the Cantonment Acts, and Regulations of that Country, (May 1888), International Documents Collection, Parliamentary Library, Wellington, New Zealand

¹⁶ Philippa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire*, (New York, 2003), p. 4

¹⁷ Arnold, *Colonizing the Body*, p. 83

¹⁸ Douglas M. Peers 'Imperial Vice: Sex, Drink and the Health of British Troops in North Indian Cantonments, 1800-1858' in *Guardians of Empire: The Armed Forces of the Colonial Powers c.1700-1964*, Eds. David Killingray and David Omissi, (Manchester, 1999), pp. 25-52

approach and transmitting a canker to their progeny.¹⁹ Prostitution was not just creating a health problem, but was also undermining the British authority. It is possible to consider infected women passing the disease on to colonial soldiers as a form of subconscious biological resistance to colonial control.

The importance of the army was not just one of military power. The military had become representatives of the morality of the empire. Following the Crimean War attitudes towards the army, and in particular the common soldier, had begun to change.²⁰ Previously considered, in the Duke of Wellington's words "the scum of the earth", the army prior to the Cardwell reforms consisted of a life of poor pay, flogging and effectively lifetime enlistment. However, press reporting of conditions during the Crimean conflict created a new sympathy for the ordinary soldier. Famously, W.H. Russell provided vivid descriptions to the readers of *The Times*. His reports of "rotten and festering corpses of the soldiers, who were left to die in their extreme agony, untended, uncared for" enlightened the home-front and engendered compassion for the soldiers serving abroad.²¹ Public interest developed over the conditions in the army, which represented and protected the Empire. Along with this compassion however, was an expectation of civilized behaviour and Christian morality. Syphilis, long considered a disease of the morally depraved, was an undesirable reminder that the reality of military behaviour often fell far short of the ideal. By attempting to reduce levels of infection, the

¹⁹ Inspector General of Hospitals, Duncan MacPherson, M.D., Series 10: British Burmah, Section X, Reports on Mountain and Marine Sanitaria, (Madras, 1862), p. 376 *Selections From The Records of the Madras Government*, p. 384, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

²⁰ Olive Anderson, 'The Growth of Christian Militarism in Mid-Victorian Britain' *English Historical Review*, 86:338, (January, 1971), pp. 46-72

²¹ W. H. Russell, *The War: From the Death of Lord Raglan to the Evacuation of the Crimea*, (London, 1856), p. 181

British authorities were also attempting to demonstrate to the indigenous population a morally superior position.

Leprosy, as noted above, was not an important disease when considered on a strictly numeric basis. While public health concerns served as the premise for this legislation, the explanation for the statute and leprosy's high profile in the Victorian mindset are not found in the realms of sanitation. Nor was the pressure to introduce legislation based on spurious military necessity, as in the case of syphilis. Civilian anxiety was responsible for the demands to control the 'vagrant leper' problem seen to be affecting Indian cities. The culmination of this pressure was the passing of the Lepers Act 1898 (Act No. III of 1898). The Leprosy Act 1898 was not so much a response to a medical issue as it was a response to a societal one. Nor did this legislation arise from the indigenous milieu, although some of the local elite did support it, within certain social parameters.²² It was the response of a foreign viewpoint imposed by a colonial government that held strong opinions on social order founded in metropolitan and European preconceived notions. The stated objects of the act make this very clear. The very first sentence of the Statement of Objects and Reasons highlights the expediency of segregation as a reason for making this legislation necessary.²³ Whilst medical treatment is mentioned it is not the key feature. The focus is firmly on restriction and containment. These are not local mores with regard to leprosy. Both Hindu and Moslem religious law perceived degrees

²² *The Gujarti* newspaper expressed support for the Government's intention of segregating 'Lepers who go about the public streets begging for alms' (March 1889); while the *Shri Shivdji* was generally in favour it suggested that the better class "be kept in a separate home... and the police should not have the power to take them up." (June, 1889) *Report of Native Newspapers 1863-1937* (National Archives of India, New Delhi), University of Western Australia (microfilm)

²³ Statement of Objects and Reasons, Lepers Act 1898

of infection.²⁴ For Hindus, ostracism was a possibility once ulceration had commenced and under Moslem law there was no exclusion; both however, maintained a moral obligation of care.²⁵ Economically, sufferers could continue their livelihood; however they were excluded from many religious rites and could be barred from inheriting property.²⁶ The concept of removing leprosy sufferers from the wider community, imprisoning them as a safeguard and forbidding their participation in certain trades appears to be entirely European in its origin.

Uniquely in Madras, the Presidency had constituted a 'think tank', which was responsible for relaying indigenous opinion to the government.²⁷ This group of affluent and influential Indian men advised the Presidency of ways that conflict could be avoided with the local population. In the case of the leprosy control legislation this advice centred on the protection of the individual rights of the employed, respectable, middle-classes.²⁸ This was the very class, which the British relied on to maintain their control of this colonial possession. The indigenous elite sought protection for their affluent contemporaries regardless of the disease status of the person. However, government officials commenting on the proposed legislation recognised the ineffectiveness of disease control that excluded some of the infected.²⁹ Also it should be noted that the

²⁴ Buckingham, 'The Morbid Mark', pp 57-80. It should be noted that there was not one codified Hindu law that applied to all castes. As part of British efforts to consolidate Indian law the brahmanic *dharmasastra* achieved greater prominence, however even in this several forms of the disease were recognised.

²⁵ Buckingham, *Leprosy*, p. 31

²⁶ Buckingham, 'Morbid Mark', pp. 57-80

²⁷ Buckingham, *Leprosy*, p. 158

²⁸ Buckingham, *Leprosy*, p. 159

²⁹ "The Government of Madras considers that the small measure of compulsory seclusion proposed in the draft Bill will have no appreciable effect on the spread of the disease." From J.F. Price Esq. Chief Secretary to the Government of Madras to the Secretary to the Government of India, No. 17 Judicial, (January 1890).

local elite was no more protective of the lower-class vagrants than the British government were. As Buckingham has noted: "Liberty was perceived by the Indian middle classes as an attribute of the higher socio-economic classes, which deserved and required protection."³⁰ The legislation had to find a balance between offence and effectiveness; societal harmony and disease control. Ultimately, the Lepers Act which became more about acceptable levels of social control swung towards placation rather than suppression of leprosy. Although an all-India act, the legislation had to be enacted in each administrative region or presidency before it was applicable within a region.³¹ In Madras itself, the Act was not used; bye-laws that had previously existed remained the main tool of leprosy control in the presidency.³² The Act was a piece of public relations, based on a negotiated position which aimed to mollify potential political opponents from the Indian middle class who could have used the legislation to focus local antagonism to colonial rule.

The core of the Lepers Act centred on social regulation of a certain population. The limited reference to medical intervention within the Act evidences this. Doctors and medical officers did not instigate enforcement of the act. Initial enforcement of the Leprosy Act was the responsibility of the police, or indeed any one appointed by the state

Further opinion noted: "The Bill under consideration secures the public against the vagrant and pauper, but leaves it at the mercy of leper dealers, traders... etc. The danger of contagion by personal contact is much greater in the case of lepers have a 'visible means of subsistence'." From the Honourable J. H. Spring Bransom, Acting Advocate General to the Chief Secretary to the Government (July, 1889), *Papers relating to The Treatment of Leprosy in India from 1887-1895*, Selections from the Records of the Government of India, University of Canterbury (microfilm)

³⁰ Buckingham, *Leprosy*, p. 165.

³¹ The Lepers Act 1898, Statement of Objects and Reasons

³² Buckingham, *Leprosy*, p. 171

to act in that role.³³ This bureaucratic responsibility further emphasises the social over the medical in the operation of the act. The state afforded control of this socially unacceptable group to their organ of judicial order. No warrants were required, merely the belief on the part of the arresting officer that the person in question may have leprosy and have been begging for alms. On arrest, leprosy sufferers were taken directly to the nearest police station and held there until inspected. The Inspector of Lepers was government appointed and defined by the Act as a medical officer or qualified medical man.³⁴ Specific medical attention, calling a doctor to attend the afflicted or sending the patient to a hospital were not requirements of the Act. Medical intervention was strictly for the classification of the disease status of the accused. People could be remanded in custody at the pleasure of the authorities while their status was established. Following arrest, there was the classification of the accused. The statute specifies several official forms provided to those arrested. Form A for those who proved leprosy free; form B for those who had the disease. The arrested thus were recorded and classified. Form A could be produced at a later stage should the same person be arrested in the future. Form B recorded who had the disease and therefore if arrested in the future the person could suffer harsher penalties. Once marked as a 'B' the now registered pauper leper had a further judicial hurdle to undergo, as they were brought before a magistrate. Here they were given a further form, form C, and then sent under police escort to a leper asylum, where finally medical attention could be offered. The act provided a judicial method of control, as well as allowing the registration and classification of both leprosy sufferers and paupers.

³³ The Lepers Act, 1898, Section 6: Arrest of Pauper Lepers

³⁴ The Lepers Act, 1898, Section 4: Appointment of Inspectors of Lepers and Superintendents of Asylums

A person accused under the act was not immediately confined. There was an allowance for the person to argue their position. Possibly, this acted as a preventive measure against the accidental detention of a member of the presumably more articulate middle-class. Within the Act, there were several possible occasions for the arrested person to argue the innocence of their position. However, this opportunity relied on the ability of the accused to prove either that he/she did not have leprosy or that he or she was not begging. It was still necessary for the person to undergo an inspection by the officially appointed Inspector of Lepers. As with the women accused under the Contagious Diseases Acts there was an assumption that the government has authority over the accused's body. If this officer was convinced that the person in front of them did not have leprosy then he was able to release them – along with the appropriate classification. Unfortunately, if unconvinced, the Inspector had the power to remand the accused in custody for the purposes of examining the disease's progress at a later stage or ordering the potential leper to appear before a magistrate. Here again, the arrested could mount a defence, but the chief witness called would be the Inspector of Lepers - something of a no-win situation for the defendant. As the Act states the magistrate could “adjourn the enquiry from time to time, remanding the person for observation or for other reason to such place as may be convenient, or admitting him to bail.”³⁵ Thus even before any conviction had been made against him, it was possible to remand a leprosy sufferers in custody for some time. The final opportunity to avoid confinement in a leprosy asylum relied on a defence against poverty rather than against disease. If a friend or relative guaranteed in writing to provide care for the accused and to prevent further public begging then the magistrate

³⁵ The Lepers Act 1898, Section 8: Procedure with Regards To Pauper Lepers

could release the arrested person, whether leprosy affected or not, into this person's care.³⁶ However, guarantors had to satisfy the magistrate of their reliability and could be required to provide a financial bond. Effectively, this clause allowed for the private removal of the leprosy afflicted off the streets and out of the public space. People accused under the Act, did have the chance to defend themselves, nonetheless, even with a successful defence, they were removed from the streets, categorised and subject to official examination.

As noted above, this act had little to do with health control and more to do with social management. A reading of the Leprosy Act shows medical aid to be of minimal importance. Although the 'Definitions' of the legislation include terms such as leper asylum and district magistrate, the term medical treatment was not defined.³⁷ The term medical treatment appeared in two forms in the Act. Firstly it appeared as an appendage to the segregation of the lepers; being 'expedient to provide for the segregation and medical treatment of pauper lepers'. Secondly, it was a requirement of any place appointed as an asylum; ensuring 'adequate arrangements have been made or will be made for the accommodation and medical treatment of lepers therein'.³⁸ In the nineteen sections of the Act there was no other mention of medical care. No minimum level of care or facilities was defined. Even with regard to the asylum itself, according to the Lepers Act alone, any place could serve. Other than these two minor references medical treatment for the incarcerated was not a goal of the legislation. Nor was there included any specifications of the staffing of the asylum, with the exception of the Inspector of

³⁶ The Lepers Act 1898, Section 8: Procedure with Regards To Pauper Lepers

³⁷ The Lepers Act 1898, Section 2: Definitions,

³⁸ The Lepers Act 1898, Section 3: Appointment of Leper Asylums by State Government

Lepers and the Superintendent of the Asylum. The superintendent could be anybody, with no qualifications or medical training. Whilst this may have been a mostly administrative role, the supervisor was responsible for the day to day running of an institute caring for patients with many medical issues. The inspector, as previously stated, was required to be a ‘medical officer or qualified medical man.’³⁹ The report made by Principal Inspector Cole to Secretary to Colonel Marshall, Secretary to Government, Military Department, however, notes that all the Presidency districts were under the professional charge of a surgeon or assistant surgeon.⁴⁰ A medical officer was regularly referred to as having responsibilities including a presence on the asylum board, initial diagnosis and quarterly inspections. Medical facilities and treatment varied between the facilities and some provided greater care than others.⁴¹ However, there is no specific stipulation in the legislation that a medical officer should be permanently present at the asylum or that he should offer regular treatment to the confined.

Along with containment of pauper leprosy sufferers, the Act’s second function was the restriction of trade and actions by those presumed to have leprosy - here again the necessary qualification was the presence of ulceration. Many of the trades included could possibly have allowed lepers to refrain from begging. The three areas specified include food, water and transport. Although a fourth category vaguely referred to “any trade....which may by notification be prohibited.”⁴² The first of these food prohibited

³⁹ The Lepers Act 1898, Section 4: Appointment of Inspectors of Lepers and Superintendents of Asylums

⁴⁰ Reports on Mountain and Marine Sanitaria, (Madras, 1862) *Selections From The Records of the Madras Government*, p. 384, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

⁴¹ Robertson, pp. 474-517

⁴² The Lepers Act 1898, Section 9: Power to Prohibit Lepers from Following Certain Trades and Doing Certain Acts

lepers from engaging in any preparation or sale of food, drink, drugs or indeed, clothing intended for “human use” - the suggestion being that leprosy sufferers were sub-human. Given the lack of any contemporary evidence that this was a possible mode of contraction the only conclusion can be the aesthetics of buying food from a person with highly visible signs of leprosy. The second category, water, restricted the use of public water supplies. Bathing, washing or just the taking of water from public wells debarred to leprosy sufferers became a fineable offence. Finally transport, leprosy sufferers were effectively barred from public transport. They could not “drive, conduct or ride in any public carriage”; however train carriages were available to them.⁴³ Again, there seems to be no logic behind the choice of restrictions, apart from the distaste of Europeans hiring a taxi driven by a visible leprosy sufferer. Upon accusation, the Inspector of Lepers became the arbiter of fate – Certificate A being a clearance; Certificate B classification as leprosy. Unlike the pauper lepers however, there was no initial confinement. Those found guilty were subject to a fine only; although further offending could result in exclusion from the locality. As well as this, if the accused could not provide sureties of future good behaviour, then it was possible that the authorities could confine him to the leper asylum. This created something of a no-win situation for the accused trader – he could not earn the money to provide a bond, being prohibited as a leprosy sufferer, thus the law rendered him a pauper and as such he could be confined to an asylum. The legislation therefore not only restricted any possible sources of income for leprosy sufferers, but also sought to reduce them to poverty. In a sense, the law first created the diseased paupers, then confined and excluded them from society.

⁴³ The Lepers Act 1898, Section 9: Power to Prohibit Lepers from Following Certain Trades and Doing Certain Acts

The analysis of the 1898 Leprosy Act above highlights the importance of social regulation, which was the impetus behind the formation of the legislation, over medical attention. The focus on removal and judicial classification and the low priority assigned to medical areas underlines this. Its goals were primarily the elimination from public spaces of visibly ulcerated vagrant lepers. Legislation to be useful requires an appropriate level of enforcement. The burden of this fell on the local police forces, for whom the act provided the power to arrest alleged offenders without warrant and without fear of personal prosecution.⁴⁴ Thus, having emphasised the physical danger leprosy sufferers represented to the public, it was then expected that another group would be willing to come into close physical contact with them to arrest them. Policemen were, however, reluctant participants. Personal distaste, overwork, understaffing and the inadequacies of the legal definitions, all combined to render the act unexploited.⁴⁵ The Lepers Act, which had not properly defined several of its key features and lacked any organisation to promote its implementation, became an example of futile legislation. Following the passing of the Act, there was an increase in the number of inmates at leper asylums; however, this was mostly voluntary and possibly the result of fear of lifetime involuntary incarceration.⁴⁶ The Lepers Act from its inception failed to achieve its goals and was, for all intents and purposes, impotent.

⁴⁴ The Lepers Act 1898, Section 6: Arrest of Pauper Lepers, Section 18: Protection to Persons Acting Bona Fide Under Act

⁴⁵ Buckingham, *Leprosy*, p. 186-7

⁴⁶ Ibid.

With these pieces of legislation, Victorian upper and middle class society accepted two concepts: firstly the idea that biology could equal guilt and secondly that there were perfectly legitimate reasons for removing citizens from the streets and confining them for the term of their potential infection, which in the case of leprosy and syphilis could effectively mean life. From its first inception the Contagious Diseases Act was controversial, provoking heated debate as to its moral, medical and legislative justification.⁴⁷ This debate caused the act to be suspended, reinstituted and then eventually repealed. The Lepers Act by contrast took a substantial time to be introduced because the debate that it engendered occurred prior to its inception. One of the key elements of both debates however, was the effect the legislation would have on the rights of the 'ordinary' people. Some of the groups opposed to the legislation still adopted the conceptual link between morality, disease and criminalisation. Opposition propaganda played on the idea that people who did not deserve arrest, such as the wealthy leprosy sufferer or the well-behaved working class woman could still be a target. Implicit in these arguments against the act was the idea that biology criminalized those arrested. There was also the acceptance that those of a certain class suffering from a certain disease could justifiably be confined. This can be compared to Victorian concepts of the deserving and undeserving poor, as well the Criminal Tribes Act in India, which condemned people on the basis of factors beyond their control.⁴⁸ The rights of those sufferers who were diseased and therefore legitimately confined for an indeterminate period were not under discussion. For the groups opposed to the Contagious Diseases Acts the women in need of protection were those working-class women from 'good

⁴⁷ Edward J. Bristow, *Vice and Vigilance: Purity Movements in Britain Since 1700*, (Dublin, 1977), p. 79

⁴⁸ Pat Thane, 'Women and the Poor Law in Victorian and Edwardian England' *History Workshop*, No. 6, (1978), pp. 29-51; Yang, pp. 108-127

homes' who were falsely accused.⁴⁹ Prostitutes arrested and incarcerated were not innocent victims, their arrest constituted what was effectively an occupational hazard. Those opposed to the Lepers Act sought to ensure that there was protection against false accusation of men from good families and that the civil rights of the middle-classes were protected.⁵⁰ There was an effort to delineate socially acceptable boundaries for the legislation and equally an acceptance that there were sufferers of disease who were guilty.

The groups established to oppose these two acts did differ in their nature. From the moment the Contagious Diseases Acts passed into law in the metropole women led the campaign against it. Admittedly these women were from a different class to those targeted by the law. They did however, forge strong links with religious societies and male working class organisations. Following the introduction of the act into India, these same women instigated a determined effort to repeal the act throughout the empire. Local antagonism within India to the Contagious Diseases Acts was minimal at best. European women sought to remove the act and protect indigenous women from a life of immorality. Whilst British campaigners did interview indigenous women as part of their efforts, there is no evidence of local women speaking out against the act themselves.⁵¹ Nor is there evidence of native male groups joining in against the act. By contrast the Lepers Act was a topic of debate amongst the indigenous elite males. As noted above letters in the local newspapers argue for protection of civil rights and possible damage to

⁴⁹ Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State*, (Cambridge, 1980), p. 109

⁵⁰ Buckingham, *Leprosy*, p. 159

⁵¹ Elizabeth W. Andrew & Katharine C. Bushnell, 'Seeking the Outcast' *The Queen's Daughters in India*, (London, 1899), pp. 17-18, <http://onlinebooks.library.upenn.edu>

reputation if one were falsely accused. Wary of prompting social unrest, British authorities were aware of these local concerns and ensured that the final construction of the act made the class demographic very specific in the act. Thus whilst both laws drew middle-class opposition to them, the Contagious Diseases Acts, which targeted the predominantly poor, lower caste female aroused little local comment; the Lepers Act which could affect males stimulated debate and prompted authorities to move with greater caution. For the Indian population, the disease was as important as the gender and caste targeted by the legislation.

Despite widespread support, neither the regulations nor the legislation were universally accepted. Certainly in the metropole the Contagious Diseases statute would face substantial opposition after its introduction in 1864. In British India, the lock hospital system, as the legislated regulation and compulsory treatment of women was known, would fall in and out of favour. Operating from its inception until 1884, then re-established in 1887, the system was only finally abolished in 1888.⁵² Officially compulsory confinement ceased, although an investigation in the 1890s reported that the lock hospitals were now apparently ‘voluntary’ venereal facilities.⁵³ Much of the support for the system came from officers in the British army, who were quite pragmatic in their view of prostitution. The Commander in Chief in Madras wrote in 1888: “The efficacy of those regulations in diminishing the amount of that disease especially in its worst form was fully proved in 1885, when the Act was temporarily suspended at 15 stations in India and that suspension was followed by a large increase of venereal disease at those

⁵² Levine, *Prostitution, Race and Politics*, pp. 91-92

⁵³ Ronald Hyam *Empire and Sexuality: The British Experience*, (Manchester, 1990), p. 126

stations.”⁵⁴ Statistics for the period are somewhat unreliable and both supporters and detractors used them to bolster their claims. Opposition to the regulations in India tended to focus on the British Army’s tacit support of prostitution as its main reason for disapproval. In their report “The Queen’s Daughters in India” Elizabeth Andrew and Katherine Bushnell frequently referred to “state-regulated fornication”, military licentiousness and official procurement.⁵⁵ Whereas the debate surrounding the Lepers Act preceded its enactment, the Contagious Diseases Act was first passed and then engendered opposition.

As noted above the movement for repeal of the Contagious Diseases Act in the metropole began almost as soon as the act itself came into existence. In India, the push for repeal did not originate from the indigenous population, but was an extension of the anti-legislation efforts in Britain. Opponents focused on a range of weaknesses in the act. Constitutional, moral and medical objections rallied a variety of groups and individuals to demand repeal.⁵⁶ Most famously in Britain Josephine Butler led the Ladies’ National Association for Abolition. Butler encouraged Elizabeth Andrew and Katharine Bushnell who travelled to India and investigated the situation there. The product of this investigation was a small book entitled “The Queen’s Daughters in India”.⁵⁷ As noted in the introduction of this work “They print the outrageous falsehoods that represent India as having become a menace to the health of England because of the abolition of brothel slavery in that country. Excuses are made for the shallow-brained sophistry of those who

⁵⁴ Minute by His Excellency the Commander in Chief Madras dated 23rd January 1888 “Correspondence between India Office, 1888” NZ Parliamentary Library

⁵⁵ Andrew & Bushnell, *The Queen’s Daughters in India*, p. 34,

⁵⁶ Bristow, p. 80

⁵⁷ Andrew & Bushnell, *The Queen’s Daughters in India*

pretend that the compulsory periodical examination of women can be divorced from the moral debasement of women”.⁵⁸ It goes on state that the medical examination is “surgical rape” as well as lamenting “licensed vice”.⁵⁹ In this one document it is possible to see the combination of outraged morality and concern over female exploitation that was at the heart of opposition. In the metropole at this time anti-vice organizations reached a peak in popularity, further fanning opponents of an Act which offered state sanction to iniquity.⁶⁰ The Act was eventually repealed in 1888.⁶¹ However, Bushnell and Andrew found many of the essential elements of the Contagious Diseases Acts continued to operate as late as 1899.

The controversy surrounding the introduction of the Lepers Bill in 1889 preceded its introduction by decades. The idea of confining the leprosy afflicted had first been raised in the 1840s. However, the continuing debate over the nature of the disease and its means of transmission rendered any argument contestable. In 1873, Hansen identified the causative agent as a bacterium which added considerable weight to the contagion theory.⁶² This did not in itself create a demand for the confinement of those affected by leprosy, particularly because of the link between race and leprosy. Europeans still perceived themselves to be immune. As Daws has noted “As long as Westerners could comfortably maintain that leprosy was hereditary, and at the same time primarily a disease of the dark-skinned, the primitive, the poverty-stricken... there was no cause for

⁵⁸ Andrew & Bushnell, *The Queen's Daughters in India*, p. 5

⁵⁹ Ibid.

⁶⁰ Bristow, p. 2.

⁶¹ Harrison, *Public Health*, p. 75

⁶² Skinsnes, ‘Notes from the History of Leprosy’, pp. 220-239

alarm”.⁶³ When Father Damien died in April 1889 this assumption was badly shaken. By June of the same year a bill was introduced to segregate leprosy sufferers in India.⁶⁴ This bill, which also focused on itinerants affected by leprosy, caused concern for two reasons. There was a desire to avoid upsetting the Indian elite by including them in such restrictive legislation and invading their private space. There was also an awareness that an act that only targeted some leprosy sufferers could only ever be partially effective.⁶⁵ While this attempt was abandoned as useless, another attempt was made in 1896.⁶⁶ Here again debate focused on the protection of elite Indian civil rights. There was local support for the control of vagrant lepers, but fear over abuses of power.⁶⁷ For both the Indian upper class and the colonizers, the vagrant represented a public nuisance; essentially an uncontrolled nomadic danger. The final version, the Lepers Act 1898, specifically targeted vagrant lepers, with a built in opportunity for appeal on the basis that the leprosy affected person was no longer vagrant. It was, nevertheless, a negotiated compromise, that was as ineffective as its predecessors as a method of disease control.

When threatened by leprosy and syphilis British colonial government responded with legislation, experimental medical treatments and new sites of control – leper and lock hospitals. Beyond any characterisation of these diseases, the character of colonialism and how this was affected by the presence of leprosy and syphilis requires investigation. British colonialism perceived itself as being of positive benefit, a ‘civilizing’ force, to those areas it controlled. This image was crucial to the construction of an ideal colonial

⁶³ Daws, p. 7

⁶⁴ Buckingham, *Leprosy*, p. 157

⁶⁵ Buckingham, *Leprosy*, p. 159

⁶⁶ Buckingham, *Leprosy*, p. 181

⁶⁷ Buckingham, *Leprosy*, p. 182

society. For the British in India this was a threefold image: the European image of themselves, the classification of the indigenous society and the formation of indigenes into a colonial mould. Leprosy affected each of these areas. The colonisers' image of themselves was predicated on an inherent white supremacy.⁶⁸ White Europeans saw their society's structure and people as better – rational, disciplined, hard-working and scientific. However, as Catherine Hall has pointed out this hierarchy required constant maintenance as it was “neither inherent nor stable”.⁶⁹ In the latter half of the nineteenth century, western medicine had developed to a point where its efficacy was deemed greater than indigenous medicine by the British medical profession. European scientific advances gave white doctors a feeling of superiority.⁷⁰ Leprosy and syphilis undermined this superiority. Neither was treatable and indeed the main form of treatment for leprosy relied on a local Indian remedy – Chaulmoogra oil.⁷¹ This unstable superiority was further degraded when high profile Europeans, such as the recently sainted Father Damien, contracted this disease of inferiors. One contemporary of Father Damien's suggested that leprosy was the result of the priest's “vices and carelessness”.⁷² This comment reflected the common belief in the sexual transmission of leprosy. As a result, ‘tainted blood’, that is racial mixing, became a possibility when considering those Europeans who did contract the disease.⁷³ This fear of covert weakening of the colonial power can only have added to the general European revulsion of leprosy sufferers. One

⁶⁸ Arnold *Colonizing the Body*, p. 43

⁶⁹ Hall, *Civilising subjects*, p. 17

⁷⁰ Worboys, pp. 207-218

⁷¹ Buckingham, *Leprosy*, p. 91

⁷² Rev Dr C. M. Hyde to H. B. Gage in Robert Louis Stevenson, *Father Damien: An Open Letter to the Rev. Dr Hyde of Honolulu from Robert Louis Stevenson (With Statement by Mrs Stevenson)*, (Notre Dame, Indiana, 1911), p. 4, (First published 1889)

⁷³ H.V. Carter MD, Bombay Army, ‘The Pathology of Lepers; with a note on the segregation of lepers in India’, *Medico-Chirurgical Transactions*, (1873), pp. 267-284
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1988896/pdf/medcht00004-0337.pdf>.

letter to the British Medical Journal suggested that: “The spread of leprosy has been favoured by the unbridled liberty allowed to lepers in India...and that we are now threatened with it at home”. Thus leprosy represented a threat to the metropole, as well as demonstrating the inadequacies of the western scientific system.⁷⁴ Visible sufferers were a constant reminder to the rulers and the ruled that the British system did not necessarily work in India.

A key facet of the civilizing mission image was that of the civilized native; the formation of indigene into an acceptable Euro-centric mould. In essence, the British applied Darwinian theory. As Russett stated: “Social sciences bathed in the light of Darwin’s Origin of Species.”⁷⁵ The colonisers attempted to evolve Indian society towards the pinnacle that was British society. If the locals were childlike then presumably they could progress towards adulthood, with all the appropriate white attributes of discipline, rationality and a European work ethic. Fanon noted ‘the colonized is raised above his previous status in direct proportion to his adoption of the language and culture of the colonizer.’⁷⁶ Indeed, early missionary efforts focused on education rather than health as the means to reach the souls of the Indians. The British sought to discipline the mind of the local to one that was recognisably white.⁷⁷ The ability to work and obey authority

⁷⁴ Frederick Simms, ‘Etiology of Leprosy’ *British Medical Journal*, (June 1889), p. 1491

⁷⁵ Cynthia Eagle Russett, *Sexual Science: The Victorian Construction of Womanhood*, (Cambridge, Massachusetts, 1989), p. 52

⁷⁶ Fanon, p. 18

⁷⁷ This move from the somatic to the intellectual replicates changes in other areas of social control in Victorian Britain. Similar issues are discussed with reference to the development of the penitentiary system in Britain by Michael Ignatieff, *Just Measure of Pain: The Penitentiary in the Industrial Revolution 1750-1850*, (London, 1978)

were taken as signs of improvement.⁷⁸ However, India and Indians could not be viewed as a society moving towards modernisation if there were uncontrolled and uncivilized examples of cultural failure visible, openly begging and displaying their wounds on the streets of every large urban centre. The pressure to render these unpleasant reminders invisible, therefore, developed in part as a response to the desire to show British colonial power as a modernizing force. Given that disease had long been linked to the ‘native influence’, the high visibility of leprosy sufferers undermined ideas of progress.⁷⁹ It is also not surprising that some indigenous urban residents were critical of the presence of large numbers of disfigured leprosy sufferers begging on the streets.⁸⁰ Leprosy not only therefore became associated with backwardness and superstition, but also visibly revealed the vulnerability of colonial authority.

One important aspect of the British perception of social order was class; this applied both at home and abroad. British legislative attempts at social control in the metropole were directed predominantly at the lower classes, which formed the majority of society. In a similar way, legislation in India targeted the lower castes, often taking the position and religious constrictions of the higher – Brahmanic – castes as the norm. Colonial government tended to conflate indigenous caste and class – lower caste equalling lower class.⁸¹ This is particularly relevant as the majority of the British serving in India were

⁷⁸ James H. Mills, “‘More Important to Civilize Than Subdue’? Lunatic Asylums, Psychiatric Practice and Fantasies of “the Civilizing Mission” in British India 1858-1900’ in *Colonialism as Civilizing Mission: Cultural Ideology in British India*, Eds. Harald Fischer-Tine and Michael Mann, (London, 2004), p. 179-89

⁷⁹ Arnold, *Colonizing the Body*, p. 89

⁸⁰ *Rast Goftar*, (June, 1889), *Report of Native Newspapers 1863-1937*, (National Archives of India, New Delhi), University of Western Australia (microfilm)

⁸¹ H. V. Carter associates higher caste with lower rates of disease, just as medicine did in the metropole. H.V. Carter MD, ‘The Pathology of Lepers’, pp. 267-284; Williams, pp. 60-88

part of the metropolitan middle-class, not the European aristocracy.⁸² The Indian princely class made the British middle-class civil servants uneasy, particularly as these aristocrats were not white and brought colonial ideas of class and race into conflict. Consequently the British bureaucracy found greater common ground with the highly literate Brahmanic cast that came to form the Indian civil service.⁸³ The higher castes were the group most useful to and most likely to initiate difficulties for colonial authority in India; their collaboration with authority ensured that the events of 1857 were not repeated. To an extent there was an exchange of values between these two groups, part of which included the association of dirt and disease with the lower orders.⁸⁴ Colonial authorities were careful to avoid offending the indigenous elite by predominantly focusing social control legislation on the lower castes. The Lepers Act and the Contagious Diseases Acts were both examples of this, although neither overtly mentions caste or class. The vagrants and women who were the target of these two acts were unlikely to be from the upper castes. The adoption of class as a factor in the legislation replicated similarities in the metropole. This pacified the middle-class and maintained the perceived social order to the benefit of the authorities in India.

The classification of the indigenous society and its relationship to British society was believed to be crucial to colonial understanding of India and the progression of the civilizing mission. In the belief that a greater understanding of the local society would

⁸² Collingham, p. 152

⁸³ Mrinalini Sinha, *Colonial Masculinity: The 'Manly Englishman' and the 'Effeminate Begali' in the late Nineteenth Century*, (Manchester, 1995), p. 4

⁸⁴ Anshu Malhotra, 'Of Dais and Midwives: Middle Class Interventions in the Management of Women's Reproductive Health in Colonial Punjab' in *Reproductive Health in India: History, Politics, Controversies*, Ed. Sarah Hodges, (Hyderabad, 2006), pp. 199-226

provide for more enlightened government, the British began very early on to categorize the native population. Census taking and its intrinsic classification began as early as the 1820s and continued throughout the nineteenth century at more or less regular intervals.⁸⁵ The 1830s saw the huge growth in the science of statistics – quantifying and cataloguing society, both in colony and metropole - with a statistics bureau established in that decade.⁸⁶ Ostensibly a method of improving local knowledge, it succeeded in reifying many elements of Indian society. As Bernard Cohn stated “the colonizer’s knowledge of the colonized was not and could never be neutral to the relation of dominance and subordination which bound them together.”⁸⁷ The British in India based local legal and governmental systems on interpretations of the census data. Combined with this was the reliance that British authorities had on indigenous literate classes, most especially the Brahmin.⁸⁸ The interpretation and classification of Indian society underpinned the basis for the treatment of diseases such as leprosy and individuals in courts of law. This constructed organisation also mirrored the imagined hierarchy of the metropole’s society, if in a less ‘civilized manner’.⁸⁹ The classification of leprosy sufferers detailed in the Leprosy Act was continuing this tradition of control and subordination through categorization.

The legislation directed at leprosy and syphilis sufferers were examples of societal classification more than they were examples of public health measures. Both acts

⁸⁵ Bernard S. Cohn, ‘The Census, Social Structure and Objectification in South Asia’ *Anthropologist amongst Historians and other Essays*, (Delhi, 1990), pp. 224-254

⁸⁶ John M. Eyler, *Victorian Social Medicine: The Ideas of William Farr*, (Baltimore, 1979), p. 13; p. 37

⁸⁷ Bernard S. Cohn, *Anthropologist amongst Historians and other Essays*, (Oxford, 1987), p. xix

⁸⁸ Waligora, pp. 141-162

⁸⁹ Ibid.

contained certification of those accused and official acknowledgement of the position of a person brought in under the acts.⁹⁰ However, vagrant leprosy sufferers and prostitutes were only two categories that required registration. Criminal tribes, castes and gender were all reified by British laws and census taking. British colonial authority, by categorising Indian society, sought understanding and a capacity to control a phenomenally diverse community. Officialdom attempted to remove fluidity and to define the boundaries of the subcultures within India. It was here the Victorians fully utilised the new science of statistics. As Scott has pointed out in her work: “Statistics established an unprecedented sense of certitude”.⁹¹ Consequently, responses to officially set census and documentation questions formed colonial attitudes and dictates. Colonial belief in the existence of a prostitute caste and a tribal group that survived through theft developed from mistaken interpretations of Indian culture and were effectively codified by legislation. Leprosy and syphilis sufferers thus fell into a socially stigmatised grouping rather than one of the medically disadvantaged. Whereas efforts to control other diseases such as cholera and smallpox were directed at the source of the infection, such as improving drainage or immunisation, this was not the case with leprosy and syphilis. Here, the treatment was distinctly different, with categorisation and stratification coming to the fore. Accordingly, the sufferers were segregated and classed by their illnesses and assigned to a legislated non-public place to ensure the continuance of perceived propriety.

⁹⁰ The Lepers Act, 1898, Section 7: Person arrested how to be dealt with; Contagious Diseases Act, 1864, Section 12

⁹¹ Joan Wallach Scott, *Gender and the Politics of History*, (New York, 1999), p. 113

Crucially, unlike other legislation, both the Lepers Act and the Contagious Diseases Act required the spatial separation of the afflicted from the general population, supporting the establishment/maintenance of specific institutions for this purpose. There was no statutory limit to the length of stay required of the incurable, placing patients' freedom in the hands of hospital administrators. Although, these establishments cannot be considered total institutions, the reinforcement of boundaries between private and public space, acceptable and unacceptable presence was made apparent by their existence.⁹²

The place most associated with the segregation of leprosy and syphilis afflicted was the leper hospital – alternatively lazar houses, asylums or retreats – and lock hospital – effectively venereal disease treatment centres. These in themselves were an area of controversy. Should these institutions be regarded as prisons to confine or a refuge to benefit sufferers? For leprosy sufferers, confinement was not compulsory until the passing of the Leper Act in 1898; therefore those using these facilities prior to 1898 were doing so voluntarily. The lock hospitals also treated voluntary admissions as well as those compelled there for treatment.⁹³ In the Madras presidency, the Portuguese had established one of the first retreats for those suffering from leprosy in the sixteenth century, which continued into the twentieth century supported by government funds.⁹⁴ The asylums provided food, shelter and respite. Lock hospitals had verandas where women could sit during the day.⁹⁵ By the latter half of the nineteenth century the variety

⁹² Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Chicago, 1961), pp. 4-5

⁹³ Surgeon General George Smith, 'Annual Report on the Lock Hospitals of the Madras Presidency for the year 1876', p. 5, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

⁹⁴ Buckingham, *Leprosy*, p. 47

⁹⁵ 'Annual Report on the Lock Hospitals of the Madras Presidency for the year 1874', *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

of places assigned to those with leprosy varied enormously – everything from small hospitals to agricultural settlements.⁹⁶ There is no sense of marking the incarcerated of asylums or locks as there was in the penitentiary system developed in the metropole.⁹⁷ However, inmates in leper asylums and lock hospitals had effectively already been marked, first by the disease itself and then by the judicial classification that labelled them. Patients were strictly segregated along gender lines. Lock hospitals were for women only, men were not confined. In leper asylums even married couples and families could be split, although this was not always the case.⁹⁸ Restrictions varied between facilities, even with the same presidency, with some inmates locked in their wards at night and high walls surrounded the building, while others were less controlled.⁹⁹ In the both pieces of legislation there were penalties imposed for sufferers who left without permission.¹⁰⁰ Therefore, whilst not entirely prison-like, hospitals were also neither an ultimate refuge nor treatment centre. The lock hospital and leper hospitals remained an odd hybrid of both.

Within the segregated spaces where patients resided, religion was a further basis of delineation. The hospitals, where possible, provided Muslim and Hindu patients with the requirements of their beliefs. However, the beliefs of the authorities were also at play in these hospitals; in part as a motivation, but also as a defining undercurrent to the treatment of inmates. Initially the facilities established by the British forces in India were

⁹⁶ Robertson, pp. 474-517

⁹⁷ Ignatieff, p. 11

⁹⁸ Papers Relating to The Treatment of Leprosy in India from 1887-1895, p. 5, Selections from the Records of the Government of India, University of Canterbury (microfilm)

⁹⁹ Robertson, pp. 474-517

¹⁰⁰ The Lepers Act 1898, Section 12: Re-arrest of escaped lepers; Contagious Diseases Act 1864, Section 17

secular, government hospitals and these would continue into the twentieth century.¹⁰¹

From the 1880s onwards, however, British evangelical Christianity came to permeate many areas of medicine, charity and penal control.¹⁰² This religious fervour motivated the staff in the secular hospitals as much as it did missionaries. For leprosy and syphilis though, the impact of these Christian beliefs differed significantly. In the case of leprosy, biblical references justified much of the care and the establishment of charities which were to become the predominant providers of hospitals and asylums to leprosy sufferers. British religious feeling provided the motivation for much of the work performed. There has been some suggestion that the asylums were used as a site of conversion, but this is debateable.¹⁰³ By contrast, for syphilis sufferers and the women of the lock hospitals in India, conversion was not a motivating factor amongst the caregivers. These attitudes were more likely to be found amongst those campaigning for the repeal of contagious diseases legislation than those promoting it. Though, this was not the case in the metropole, where preaching and attempting to redeem the fallen woman was a part of the lock hospital process.¹⁰⁴ In India, there was a sense that the women were born to this role and expected the disease as an aspect of their function. In essence, they were neither redeemable nor worthy of the effort – the undeserving sick. Although in the European context leprosy and syphilis had a long history of concatenation, in the colonial setting there was an almost moral separation. In one African colony, authorities utilised the moneys collected for the treatment of syphilis to

¹⁰¹ Buckingham, *Leprosy*, p. 37

¹⁰² Robertson, pp. 474-517

¹⁰³ Kakar, pp. 215-230.

¹⁰⁴ Walkowitz, p. 60

pay for the leprosy hospital.¹⁰⁵ Indigenous religions may have been exploited to further delineate the native population, but it was the colonial beliefs that were exercised in the decision making process and the management of the diseased.

For the British government in India, missionary assistance with the care of leprosy sufferers became an increasingly important asset. Effectively, as the century progressed, the treatment for patients moved further into the hands of missionaries and away from secular ones.¹⁰⁶ The motivation for this was partly economic and partly pragmatic. Following the founding of the Mission to the Lepers in 1874, the number of charitably based leprosy hospitals increased significantly.¹⁰⁷ This was not the case for lock hospitals, which continued to be government funded and steady in number. The Mission to the Lepers was in short order considered an expert in the area of leprosy care. Given that the government could nominate any place as an asylum, it made practical sense to apply this to existing charity establishments and provide financial grants to assist them.¹⁰⁸ In this way, Christian based organisations developed the principal position in the field of leprosy treatment. This has led some to argue that efforts at conversion overrode medical care of the patients. Kakar, in particular, noted “the religious character of the asylum, including denial of freedom of worship and mandatory Christian teaching, also produced inhospitable conditions.”¹⁰⁹ However, this assumes a conformity that was not a reality. As well as this provision of the best possible care was an essential element of the

¹⁰⁵ Vaughan, p. 147

¹⁰⁶ Buckingham, *Leprosy*, p. 187

¹⁰⁷ Kakar, pp. 215-230

¹⁰⁸ Buckingham, *Leprosy*, p. 187

¹⁰⁹ Kakar, pp. 215-230.

Mission's rationale.¹¹⁰ Elsewhere, Edmond has compared some leper colonies to Goffman's "total institutions", with their isolation and mortification of the self.¹¹¹ In the main, however, Edmond is referring to offshore colonies. The asylums of the Madras presidency do not fit this model. Most commonly they were located in near proximity to the urban centres. Nor could the leprosy sufferers themselves be considered isolated as they were noted for their mobility.¹¹² Practically, missionary assistance provided the government of India with much extra funds as well as additional facilities for leprosy sufferers. The asylums may have had a Christian foundation, but their location and the nature of the patients made them a space for negotiation.

One important factor when examining legislation is a consideration of the success of the act in achieving their desired goals; in this case the explicit goal of disease control and the implicit goal of societal regulation. With the overt purpose of reduction of infection, efficacy can be measured in the number of people contracting these illnesses; however neither resulted in any substantial lessening of either syphilis or leprosy. Army reports indicate rates continued at pre-legislation levels for syphilis and whilst the reported numbers of leprosy sufferers, may have increased the overall population does not appear to have declined.¹¹³ From a modern perspective this is hardly surprising given the limited focus of the acts and even nineteenth century commentators argued the acts were pointless from a medical standpoint.¹¹⁴ The success of the underlying aims of the acts is

¹¹⁰ Buckingham, *Leprosy*, p. 30

¹¹¹ Edmond, *Leprosy And Empire*, p. 144

¹¹² Kakar, pp. 215-230.

¹¹³ Ballhatchet, p. 53

¹¹⁴ "The Madras Government considers that there is no reasonable room for doubt that, it is intended to stamp out or materially reduce the disease, something far more thorough than the proposed legislation is essential." Right Honourable Viscount Cross, Her Majesty's Secretary of State for India to His Excellency

more difficult to assess. Although there is no evidence that there was a reduction in the number of prostitutes or levels of syphilis, women did elect to register and undergo examination in accordance with the regulations. This was not the majority of women sex workers, but it does suggest that a portion of the population were willing to accept these regulations and believed that some advantaged accrued from this. Whether or not the enlisted men only attended the registered women is impossible to ascertain, although the authorities' concern over clandestine sex workers implied there were many who did not use the authorised facilities. Equally, the removal of leprosy sufferers from the streets and their confinement to asylums was limited. Police, who had the primary responsibility for the detaining of vagrant leprosy sufferers, were reluctant to deal with the problem. Firstly, social, religious and biological fears meant that most officers did not want to handle the body of an infected person.¹¹⁵ Secondly, low staff levels required the allocation of human resources to more pressing issues than the arrest of a few beggars. The level of inmates in leprosy asylums did show an increase, though this was more a result of voluntary admissions than legal confinement.¹¹⁶ Thus on all levels – as a method of disease control, as means of population management and as a support to colonial power – both pieces of legislation failed to accomplish any significant level of success.

the Most Honourable Governor General, 5th September, 1889, *Papers Relating to the Treatment of Leprosy from 1887-1895*, Selections from the Records of the Government of India, University of Canterbury (microfilm)

¹¹⁵ A. Donald Miller remarked after the Lepers Act was introduced that “It was seen that the normal policeman is not keen to arrest beggar lepers”. A. Donald Miller in Jane Buckingham, *Leprosy in Colonial South India*, (Basingstoke, 2002), p. 187

¹¹⁶ Buckingham, *Leprosy*, p. 186

One of the central reasons for the minimal achievement of the Lepers Act and the Contagious Diseases Acts was the Eurocentric design of the statutes. This design included British ideas of both race and class. Neither act had a precedent in indigenous law. Both were very much the offspring of European legislations that were imported and adapted to India. The legislation concerning leprosy had its basis in the methods adopted by the Norwegian government. Here sufferers were criminalised and confined, although again wealth and status provided some protection, allowing those who could afford it to remain in their homes.¹¹⁷ However, the Norwegian legislation did not specifically target any sector of society, such as vagrants. In India the British refined the act, directing it towards an undesirable group rather than all sufferers of leprosy. For syphilis, the act had its origins in an identically named piece of legislation that was introduced into certain barrack towns in the Metropole. Whilst the metropolitan act did attempt to control women of a certain class, the confinement itself was used as a means of redeeming those designated fallen women.¹¹⁸ Redemption and retraining were not a part of the act in India. Further, in Britain the act never extended beyond a small number of defined cities nor did it support a register of women or the establishment of brothels, as the cantonment regulations in India did. It seems that in India a different morality held sway. Although a similar class of women were the focus of the Contagious Diseases Acts, there was a tacit acceptance of the necessity of prostitution for the predominantly male European population and the belief that Indian culture tolerated this position for its women.¹¹⁹ The act became a way of curbing the excesses of this necessity rather than eliminating it.

¹¹⁷ Richards, p. 93

¹¹⁸ Walkowitz, p. 221

¹¹⁹ 'Report of Health Officer of Madras upon the working of the Contagious Diseases Act in Madras for the year ending 31st March 1877', *Extracts from the Annual Reports on the Lock Hospitals*, (1876), Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

Thus class and race shaped both acts when exported from the British Isles with an aspect of social control becoming an essential adaptation.

The Lepers Act and the Contagious Diseases Act shared the same cultural and historical origins, despite some thirty years separating their establishment. Each act represented an example of the colonial codification of the Indian legal system and the classification of the indigenous population. The acts were a part of the effort to define and control the enormous multilayered resource that India represented to the British Empire. European society found these diseases visually repellent and for those infected, the morality of their behaviour was suspect as well as their fitness to reside in society. However, not all the infected were treated equally and it is in the understanding of this that the similarities of these two pieces of legislation become most apparent. Neither act targeted or even attempted to target all sufferers of leprosy and syphilis. Those who were likely to be affected by the legislation were poor, lower caste and isolated from their own community. The people, who were the subject of the laws, formed a component of the marginalised, uncontrolled societal fringe. Therefore both acts can be seen as products of social regulation, in the same mould as The Criminal Tribes Act and the Vagrants Act. These targeted subcultures were highly visible distinguishable groups that could be isolated and removed, demonstrating British control. Class, and in the case of India, caste was an essential demarcation of this regimentation, especially when linked with poverty. In each act this was clear if not explicitly stated. Racial characterisation, which subtly highlighted the superiority of the European population over the indigenous, was also a tacit component of the legislation. The eurocentric basis of the two acts further

emphasizes this. This importation of European style treatment also accounted in part for the notable lack of success that each act achieved in controlling leprosy and syphilis.

Differences did exist between the two acts, however, the similarities in their cultural foundation and the manner in which they were implemented reveals the shared milieu that created them.

Section Three - Construction of the Visibly Diseased Body:

The Contagious Diseases Acts and the Lepers Act were an attempt by colonial authority to regulate the pauper leprosy sufferers and common prostitutes of India. As Arnold stated “Colonialism used the body as a site for the construction of its own authority, legitimacy and control”.¹²⁰ In the context of these pieces of legislation, authority had selected specific bodies as representative of these diseases. Government chose to act only on the visibly diseased. The identification of these ‘bodies’ had its foundation in cultural, political and racial characterisations that had little reference to the reality of the diseases’ pathologies. The target disease of the legislation may have been overtly differentiated by the named biological focus, but as will be demonstrated, many of the motivations that underscored the selection of the ‘offenders’ were very similar for both acts. The Acts constructed a diseased body that incorporated particular visible factors other than the presence of leprosy and syphilis. Although race was not mentioned specifically in either piece of legislation, there was definitely a racial factor in the acts. For the British in India, skin colour was an obvious visible marker of the exotic otherness of the indigenous population. Further, the social class of the afflicted was a fundamental feature of the legislation, essentially reflecting the hierarchy of the metropole. In the nineteenth century, the lower classes, and comparably in India lower castes, were associated with the unsanitary, ill-discipline and those requiring patriarchal assistance.¹²¹ Victorian social commentator George Godwin, while referring to the slum areas of

¹²⁰ Arnold, *Colonizing the Body*, p. 8

¹²¹ Mort, p. 37

London, highlighted two issues that were as relevant to India as the metropole, the urban masses inhabiting the city and the use of disease metaphors to emphasise the issues.¹²² Finally, gender was a key feature, particularly in the case of the Contagious Diseases Acts, where it was written into the law itself. With the majority of the colonial population male, the Indian female body was the most visibly alien to their understanding. Assumptions about Indian culture by the British often based on poor observations combined with the imagined significance of leprosy and syphilis to form these laws. In turn, the pieces of legislation shaped the colonial representation of the visibly diseased body that they acted upon.

Race:

To the nineteenth century British colonial racial difference was the key visible marker between themselves and others. These characterisations were embedded in all layers of Victorian cultures – characterisations both about Indians and about the British themselves.¹²³ Assumptions about race became intertwined with the profiling of Indian society and were a part of the constructed British image of India. This construction salved the European conscience and informed behaviour towards indigenous peoples. The literature and popular culture of the nineteenth century portrayed India as a formerly great civilization. It was seen by the British in the nineteenth century as decadent and

¹²² George Godwin, *Town Swamps and Social Bridges*, (New York, 1972 c. 1859), p.1

¹²³ Mark Harrison, "'Tender Frame of Man': Disease, Climate and Racial Difference in India and the West Indies, 1760-1860' *Bulletin of the History of Medicine*, 70:1, (1996), pp. 68-93

backward.¹²⁴ For Europeans, leprosy evidenced the medieval nature of India.¹²⁵ In popular belief, this disease had not been present in Britain for hundreds of years. Its elimination represented the progress of the society. India was personified as a land in need of rescue, and modernization, like some exotic damsel in distress.¹²⁶ The use of feminine analogy to describe India was, in fact, common. The colonizers were masculine and heroic; the colonised weak and feminine.¹²⁷ There was also a very strong paternalistic air to British characterisations of India. As in the British home with its ideas of the *pater familias* ruling the household with a firm, but compassionate hand, so too was colonial rule imagined. The wise white rulers would govern the childlike indigenes.¹²⁸ The characterisation of leprosy in the Victorian imagination fitted into this characterisation of the society. Those working to alleviate the suffering of the disease became heroic campaigners, whilst those suffering the disease were poor, voiceless locals requiring outside assistance.¹²⁹ To an extent, this image of the recipient of western aid persists today.

India may have been considered exotic and unsanitary, but it was at the same time a part of the British Empire.¹³⁰ Therefore, the colonisers needed to incorporate India into their own economic, and to a degree, culture framework. It was necessary to apply a perception of Britishness to the useful and acceptable; in a sense there was an exchange

¹²⁴ Jyotsna G. Singh, *Colonial Narratives/Cultural Dialogues: "Discoveries" of India in the Language of Colonialism*, (London, 1996), p. 82

¹²⁵ Joseph, pp. 247-275

¹²⁶ Singh, p. 80

¹²⁷ David Arnold, 'Race, Place and Bodily Difference in nineteenth-century India' *Historical Research*, 77:196, (May, 2004), pp. 254-273

¹²⁸ Mills, "More Important to Civilize Than Subdue", pp. 179-89

¹²⁹ Worboys, pp. 207-218

¹³⁰ Collingham, p. 177

of cultural values. Marginalisation and/or criminalisation, however, were the fate of those groups that could not or would not be fitted into this view. Nomadic tribes, certain religious practices and diseased beggars were all outside the acceptable for British colonial authority and legislation reflected this. Indigenous elites often adapted aspects of colonially acceptable behaviours into their own culture as a way of delineating themselves from the 'other' and identifying themselves with authority.¹³¹ British ideas relating to sanitation suited Indian religious views on cleanliness and caste purity. For the newly-emergent Indian middle-class the adoption of the Anglo 'cleanliness is next to godliness' ethos evolved to fit with their own cultural view to the exclusion of indigenous lower caste servants.¹³² As in the metropole there was a growing association among the British middle classes in India of poverty with dirt and disease. For the British in India, added to this association was the racial difference between the colonised and the coloniser. Gilman asserted that blackness had long been seen as a mark of syphilis in European cultures.¹³³ It is therefore not difficult to understand how this significance was extended to a native group, who were by nature dark-skinned. Certainly in colonial Australia there was an assumption that all Aboriginal women had syphilis.¹³⁴ In India, the correlation between indigenous people and disease was never this complete. In all probability this was due to British perceptions of existing differentiations in Indian culture, and assumptions regarding skin colour markers within the caste system.¹³⁵ There was, however, an underlying uneasiness that marked all native women as suspect. Whilst

¹³¹ Malhotra, pp. 199-226

¹³² Ibid.

¹³³ Gilman, 'I'm Down on Whores', pp. 146-170

¹³⁴ Levine, *Prostitution, Race and Politics*, p. 208

¹³⁵ David Arnold, 'Race, place and bodily difference in Colonial India', *Historical Research*, vol. 77:196, (May 2004), pp. 254-273

much of the success of the British in India stemmed from the service provided by local labour, it was important to the British that this service was controlled by colonial authority. Prostitution, as a form of service to the colonials required a degree of assimilation into the British *modus operandi*. This meant the regulation and categorization of the sex workers for exploitation by colonial authority. Women who chose to register accepted this and were incorporating themselves into the colonial system. The Contagious Diseases Act and the Cantonment Regulations were attempts at assimilating this gendered, racialized community in to one that was, if not morally ideal then, at least, culturally integrated.

Although the language of the legislation did not specifically mention race, as it does for example in the Criminal Tribes Act, there is no doubt that there was a racial component. Political power, such as the ability to introduce legal acts, was one of the factors that facilitated the preservation of British supremacy in India. These acts did not say that Europeans were immune to these diseases, merely these acts did not in effect apply to those Europeans who contracted either syphilis or leprosy. The European population of India was an extremely small percentage of within the sub-continent and as such represented a small numbers in any analysis. Aside from the tiny numbers involved, efforts were made, and even specific legislation was enacted, to ensure that any visible example of white failure such as vagrancy, insanity or debilitating illness were despatched back to the metropole.¹³⁶ British residents in India who contracted leprosy generally returned home and although leprosy asylum reports separate patients by race

¹³⁶ David Arnold, 'European Orphans and Vagrants in India in the Nineteenth Century' *Journal of Imperial and Commonwealth History*, 7:2, (Jan. 1979), pp. 104-127

those Europeans referred to are in fact Eurasians.¹³⁷ Army medical staff treated soldiers with syphilis and if they recovered, soldiers returned to duty; those whom the disease debilitated though were shipped back to Britain. Indeed, this was considered one of the reasons why syphilis was such a scourge, as these diseased soldiers could then infect women back home and pass the congenital strain on to their offspring.¹³⁸ Civilians also left India and often hid their health issues. Families even persuaded doctors to alter the cause of death on a death certificate to protect their 'good name'.¹³⁹ European prostitutes were also present in India, often women from Eastern Europe, but as has been noted earlier they were a minute percentage of the whole.¹⁴⁰ The lock hospitals, however, confined and treated a predominantly indigenous population; there being little evidence of European women in the hospitals. Both leprosy and syphilis represented the failure of white superiority and consequently it was necessary also to exclude British sufferers from the societal landscape. In this way the elite maintained the vulnerable façade of European supremacy that the British constructed as a major part of the empire in India.

For the Europeans who contracted leprosy or syphilis in India there were certainly ways to avoid confinement. For many of the Europeans afflicted removal from the colony was positively encouraged. There were government efforts at this time to repatriate both the European insane and vagrant.¹⁴¹ In this way the appearance of weakness by the 'superior race' could be avoided and not demonstrated to the indigenous population. Concealment

¹³⁷ Section 1 Series V, The Presidency Division, *Papers relating to The Treatment of Leprosy in India from 1887-1895*, Selections from the Records of the Government of India, University of Canterbury (microfilm)

¹³⁸ Pandya, pp. 161-177

¹³⁹ Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, (Oxford, 1987), p. 10

¹⁴⁰ Levine, *Prostitution, Race and Politics*, p. 223.

¹⁴¹ Arnold, 'European Orphans', pp. 104-127

of the disease was also an option, especially as contraction of the disease could result in the loss of one's employment.¹⁴² This is not to say that no Europeans entered into local asylums. For those Europeans who were unable to either conceal the disease or return home this was a possibility. Europeans, though, did receive different treatment to indigenous patients.¹⁴³ This included differing accommodation, food and presumably attitudes of the staff. However, even European attitudes towards European leprosy sufferers were tinged with an element of prejudice. Some linked the contraction of leprosy by a member of the white race to ideas of 'tainted blood'.¹⁴⁴ This belief may have derived from the perceived absence of the disease in the metropole. Europe had overcome the disease and in essence was exempt from it; any who then fell victim to leprosy could not be entirely 'white'. For others, however, leprosy was a tropical disease. Therefore, leprosy was considered a disease, which was the result of exotic living. There were at least two high-profile cases of leprosy in London during the latter half of the nineteenth century and both were thought to have resulted from association with exotic climes.¹⁴⁵ Whilst not subject to the same strictures as the indigenous population, the British and European leprosy sufferers still experienced social ostracism and concealment. They may have been able to avoid compulsory containment in a leper asylum, but this did not mean that their lives were unaffected. However, the numbers involved were minimal and for many of these there were alternatives to asylum care.

¹⁴² Buckingham, *Leprosy*, p. 27

¹⁴³ Ibid.

¹⁴⁴ H.V. Carter, 'The Pathology of Lepers', pp. 267-284

¹⁴⁵ Ibid.

There was also an imperial, racially based benefit to the introduction of this legislation. The Contagious Diseases Acts' primary beneficiary was the British Army and in particular the white troops stationed in India. Although the army did include native troops, it is difficult to perceive how this group may have profited. The indigenous soldier already had a noticeably lower rate of venereal infection than his European counterpart did. He was more likely to be married and he was not officially restricted from using any unregistered prostitute in the bazaar.¹⁴⁶ Therefore although he had more opportunities to contract syphilis by using 'clandestine' women, in actuality he remained healthier. British authorities generally assumed this to be the result of acclimatisation.¹⁴⁷ White troops had a substantially higher rate of infection, were unlikely to be married and were more important to the government in demonstrating British superiority.¹⁴⁸ Since the successful government of India by the British required the continued display of control and supremacy, it was important to ensure that one of the main pillars of this – the army – was both physically and morally fit. Clearly, sick soldiers could not accomplish this.

The Lepers Act and the Contagious Diseases Acts constructed a diseased body that was racially differentiated. In both pieces of legislation, the visible characterisation of the afflicted would be one of the diseased and poor native. Each act provided a vulnerable target and one which the British government could seek to control and render invisible, with little offence to the local elite. The pauper leprosy sufferer of the Lepers Act would almost certainly be Indian. A visibly ulcerated Indian begging on the streets, who either had no family to offer support or could no longer work, was already isolated within the

¹⁴⁶ Arnold, *Colonizing the Body*, p. 84

¹⁴⁷ Harrison, *Public Health in British India*, p. 49

¹⁴⁸ Arnold, *Colonizing the Body*, p. 84

local community. One native newspaper report condemns the pauper leprosy sufferer as a more dangerous class than vagrants or loafers.¹⁴⁹ The situation was similar with the Contagious Diseases Acts. The language of the cantonment regulations was racially unambiguous, as well as distinctly gendered. References to “sudder bazar” public women, low-caste women and female “punkah-pullers” are all explicitly related to the poorest, indigenous women. In the metropole, societal authorities cast British prostitutes as working class women who were the outsiders of their own class.¹⁵⁰ To a degree, a similar approach marked British efforts in India, with two important differences, the women were already outsiders to the white society, being marked by their skin colour and there was little or no effort to convert or reintegrate them into their own society. Even within their own culture, prostitutes were on the margins of society, a society which was, as Nandy argues, historically ambivalent towards women.¹⁵¹ The diseased bodies at the heart of these acts were racially delineated and, equally importantly, identified as being from the lower socio-economic groups.

Class:

British colonial authority associated leprosy and syphilis with the lower classes, despite being aware that all were susceptible to infection. For leprosy, this association was assigned to the indigenous lower castes. Syphilis differed from this due to the levels of infection among white British enlisted men. Although having a racial association,

¹⁴⁹ *Shri Shivdji*, 14 June 1889, *Report of Native Newspapers 1863-1937*, (National Archives of India, New Delhi), University of Western Australia (microfilm)

¹⁵⁰ Walkowitz, p. 38

¹⁵¹ Ashis Nandy, *At the Edge of Psychology: Essays in Politics and Culture*, (Delhi, 1990), p. 37

syphilis was also seen as a disease of the British lower classes. Enlisted men were overwhelmingly from the lower classes, which in the metropole, was subject to similar efforts at social control as the Contagious Diseases Act in India.¹⁵² The perception of syphilis in the army reflected both the class distinctions and the racial assumptions of the wider British society. Class, education and aspirations separated the officers and men. Different regulations and standards applied to them and their status in society varied with rank. This difference informed their treatment of one another and the responses to a disease such as syphilis. Officers, in general, were members of the landed gentry or the manufacturing nouveau riche, who wished to add cachet to their family.¹⁵³ Prior to the Cardwell Reforms, which commenced in the 1860s, officers traditionally purchased their commission, in essence guaranteeing that only those with suitable financial resources could attain command. Purchasing of commissions was abolished in 1871. Although, many of the officers in command during the second half of the nineteenth century had first achieved their rank by purchase. The social class, from which the majority of officers were drawn, considered the army a suitable, even desirable career. Although, for many, the failure at either university or in Indian Civil Service exams had left the army as the only acceptable option available.¹⁵⁴ Socializing between the ranks was practically non-existent and despite some genuine concerns over the welfare of the enlisted men, in reality there was little interaction between these two groups.

By contrast with the officers, the rank and file were not the elite of society; they were not even the elite of their own class. Very few of the enlisted men had anything more than

¹⁵² Walkowitz, p. 65

¹⁵³ Spiers, p. 94

¹⁵⁴ Spiers, p. 96

basic literacy.¹⁵⁵ The average soldier received very low pay, lower than many factory workers, which was subject to numerous deductions.¹⁵⁶ Working class families did not consider the military life as an acceptable career choice: “To have a member who had gone for a soldier was for many families a crowning disgrace.”¹⁵⁷ The Cardwell Reforms, initiated by the then secretary of state Edward Cardwell, aimed to increase the levels of recruits as well as reducing the cost to the government. Two of the most important of the reforms in this regard were the abolition of flogging – a move opposed by most officers – and the introduction of short-service. The average length of service for a soldier had been twenty one years. Although this had been reduced to ten years in 1847, there was no pension available except to those soldiers who enlisted for two terms, effectively twenty years. Cardwell reduced this to twelve years, with only the first six spent in the regulars, the final six would be spent in the reserves.¹⁵⁸ This led to an increase of young, single soldiers in the army after 1870. The military authorities permitted few of these men to marry; only around six percent.¹⁵⁹ Therefore, whilst managing to increase the numbers enlisting, the government’s reforms had created a reservoir of men who were then excluded from normal societal attachments.

Consequently, syphilis became a military issue and many in the army high command backed legislation supporting the registration of prostitution. In essence while overtly the Act may have been an effort to benefit the health of the white soldier it was also in effect attempting to control his social-sexual behaviour. With this legislation, the elite

¹⁵⁵ Spiers, p. 144

¹⁵⁶ Spiers, p. 133

¹⁵⁷ Lord Wavell quoted in Spiers, p. 132

¹⁵⁸ Spiers, p. 4

¹⁵⁹ Myna Trustring, *Women of the Regiment: Marriage and the Victorian Army*, (Cambridge, 1984), p. 30

endeavoured to both control the behaviour of the lower class and prop up one of the most visible mainstays of British power in India.

Essentially, the officers and men of the army, despite serving in the same organisation, were of two different countries and the prostitutes were different from both. This difference informed their treatment. The women at the centre of this issue were defined as common or public prostitutes.¹⁶⁰ Official documents do not actually define the term common prostitute. The presumption is that this was a reference to the poorer street walkers, who were the most visible of the profession and available to anybody. The common prostitute was associated with the street and not necessarily the brothel, a place where it was possible for the women to remain invisible. The Cantonment Regulations even state that there were “Prostitutes to whom the term public is hardly appropriate.... And it does not seem desirable to attempt any more exact definition”.¹⁶¹ The inference suggested a difference in class of customer base. The common prostitute serviced an equally common soldier. Government despatches related to venereal disease in the British Army make repeated references to the common soldiery – the rank and file.¹⁶² The women targeted by the acts were those who serviced the lower-rank, and by extension lower-class, men. One member of the Council of India, Sir Arbuthnot stated baldly that syphilis affected that section of society from whom the common soldier was

¹⁶⁰ *Special Committee's Exposition of the Lock Hospital Rules*

¹⁶¹ *Special Committee's Exposition of the Lock Hospital Rules*

¹⁶² One extract speaks of large numbers of soldiers who “Gratify their strongest appetite, reckless of the consequences”. Series XI: Prostitution and Lock Hospitals at Military Stations, Reports on Mountain and Marine Sanitaria, (Madras, 1862) *Selections From The Records of the Madras Government*, p. 385, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

drawn.¹⁶³ There is no mention of higher ranks either in their contraction of the disease or their use of prostitutes. The needs of officers were, presumably, fulfilled either by the inclusion of a permanent mistress in the household or visiting of officer-only brothels.¹⁶⁴ Neither of these options was highly visible and was therefore not exposed to the same level of public condemnation by government or military authorities. The effects of syphilis on the officer class can only be surmised. Possibly infection rates of syphilis were lower; wealth provided greater access to early forms of barrier protection (condoms), and the opportunity to return home to private medical care, where the disease could be kept hidden. Otherwise, one can only assume that officers considered themselves protected by the distinction of rank from infection. The elite represented syphilis as a disease of the lower-classes and legislation targeting it was a form of social control, rather than an issue of public health.

Just as with the Contagious Diseases Act, the Lepers Act was not characterized as applicable to the elite. Both had the management of visible marginal groups as their focus. Leprosy and the legislation to control it had some discernable class based motives. The focus of the act was vagrant leprosy sufferers, those visibly ailing people reduced to begging on the street. That is, those at the bottom of the social pecking order in both the indigenous culture and the metropolitan one. Local elite debate over civil liberties had ensured that the Lepers Act did not allow for the confinement of affluent leprosy

¹⁶³ General Alexander Arbuthnot, Minutes of Dissent by Certain Members of Council of India from the Despatch Addressed by the Secretary of State to the Government of India regarding the Contagious Diseases Act, (May 1888), International Documents Collection, Parliamentary Library, Wellington, New Zealand

¹⁶⁴ Sumanta Banerjee, 'The 'Beshya' and the 'Babu' Prostitute and her Clientele in Nineteenth Century Bengal', *Economic and Political Weekly* 28:45, (Nov. 6 1993), pp. 2461-2472

sufferers.¹⁶⁵ From the outset, the leprosy legislation did not aim to control all the infected or even all with outward symptoms of the disease. Those who were targeted were poor, lower caste and indigenous, which leads one to query the benefit of such a limited effort. The key feature of these people was their high visibility in the urban streets. The leprosy sufferers specified by the Act were most likely to be seen congregating in cities and around temples displaying their ulceration in an attempt to elicit sympathy and alms. Britain's self-imposed mandate of civilizing Indian society was undermined by any visible signs of the uncivilized, uncontrolled group and it is possible to imagine that a marginalised group congregating in this way could have been perceived as a possible embarrassment to colonial rule. An inability to manage the obviously ailing beggars on city streets would constitute a failure. Not only did western medicine, another pillar of British government, fail to treat effectively this disease, but also western authority was not removing vagrants from the cities. The Lepers Act was thus a method in which to conceal this uncivilized aspect of India society. The legislation enabled authorities to remove the unsightly and infected vagrant from the street, concealing the failure of authority and medicine. Governing elites aimed to achieve very similar goals with both acts – the management of visible sub-cultures and the bolstering of colonial power.

Integral to the framework of the Lepers Act was a European desire to censure the visible examples of an uncivilized, exotic society. In the exclusionary objective of the opening statement both overt references to class and covert references to race underscore this. One of the primary groups singled out for attention - the 'pauper leper' – exemplified the socially regulatory nature of the legislation. In the definitions of the Act a leper was

¹⁶⁵ Buckingham, *Leprosy*, p. 159

defined as “any person suffering from any variety of leprosy in whom the process of ulceration has commenced”.¹⁶⁶ Further, a pauper leprosy sufferer was specified as a person without visible means of subsistence, who was either begging for charity or displaying ulceration in order to obtain alms.¹⁶⁷ The legislation explicitly concentrated on the most economically deprived and socially vulnerable section society. The regulation focused on those people seen on the streets, and those in whom leprosy was visibly present. Non-visible sufferers were not, according to the specific wording of the legislation, at issue. This is not to say that there was no awareness of the inadequacies of a piece of disease control legislation that ignored all who had the disease.¹⁶⁸ However, the negotiated position of legislation caused its focus to remain fixed on non-controversial targets. Although race was not specifically referenced in the language of the Act, it must be assumed that the paupers in question were the indigenous beggars. This is not to imply that European beggars did not exist, merely that their numbers were tiny compared to the numbers of indigenous ones. There were also specific acts aimed at dealing with the presence of European vagrancy, which operated in a similar way to the Lepers Act to criminalize those charged.¹⁶⁹ Nowhere in the statement of objects and reasons, heading up the Act, is the amelioration or protection of the condition of this group on the fringe of society mentioned. Removal of an unsightly remnant off the streets remained the key function of the piece of legislation.

¹⁶⁶ The Lepers Act 1898, Section 2.1 Definitions

¹⁶⁷ The Lepers Act 1898, Section 2.2 Definitions.

¹⁶⁸ One example is J. F. Price, Chief Secretary to the Government of Madras, who in 1890 noted that a more comprehensive approach to leprosy was required if the disease was to be stamped out. J. F. Price Esq. Chief Secretary to the Secretary to the Government of India, 9th January 1890, Papers Relating to the Treatment of Leprosy in India from 1887-1895, p. 5, Selections from the Records of the Government of India, University of Canterbury (microfilm)

¹⁶⁹ Arnold, ‘European Orphans’, pp 104-127.

Leprosy and syphilis legislation was bounded by ideas around class and the privilege of wealth. For upper-class British and Indians there was the protection of position. The elite in British and Indian society could in effect choose to render themselves invisible. This voluntary act gave them control over their own body, which was denied to those of lower classes. Upper class sufferers were able to remove themselves to the comfort of their own homes and enjoy little official interference; however, invisibility was still the outcome. This option also successfully reinforced the power of colonial authority, as the diseased body, was still removed from view. This further highlights one of the tensions that existed throughout the empire and one of the ways that British colonial power attempted to respond to it. The image of Britain as the civilizer required that the recipient, in this case India, be perceived as uncivilized. However, western medical knowledge in the nineteenth century could do little to treat leprosy, which would therefore show the civilizer as impotent. The result was exclusion and concealment; what could not be cured was rendered invisible leaving only the signs of a visibly improving society.

Gender:

Both the Lepers Act and the Contagious Diseases Acts made assumptions about the gender of the sufferer. Leprosy does have a biological gender bias, presenting in men more than women, although there were cultural features that meant men were more visible in India than women. This gender bias was not, however, written into the legislation. Presumptions about syphilis though were written into the Contagious

Diseases Act. This is a reflection of the more general assumptions that existed during the nineteenth century about women. The position of women in British Victorian society underwent a transformation. Mort, Lacquer and Johnson have all shown how the characterisation of women during the nineteenth century transformed from that of the sexual rapacious medieval model to one that was asexual and submissive, with cultural representations of gender roles hardening.¹⁷⁰ For Indian women this delineation was further emphasised by British assumptions regarding indigenous culture, assumptions made based on a limited understanding of local traditions. Prostitution was thought, by many of the British, to be a stigma-free option for certain women in India. Still current in western theory at this time was the mistaken idea of a prostitute caste. As late as 1897, one commentator stated: “Prostitutes in India form an ancient and honourable caste...and are absolutely unlikely to resent a regulation that would ensure them medical attention.”¹⁷¹ This belief stemmed from the misinterpretation of the function of *Devadasi*, known as pagoda girls. These women had married a deity and served the divine, often dwelling at the temple. There was a sexual component of their role, however, it was highly ritualised and normally took the form of concubinage to an elite male patron.¹⁷² These women were not “public” prostitutes, such as were seen in the cities. British colonial presence eroded the social position of these women. Legislation criminalised their socio-religious function, which conflated temple service with

¹⁷⁰ Thomas Laqueur, ‘Orgasm, Generation and the Politics of Reproductive Biology in the Making of the Modern Body’ in *Sexuality and Society in the Nineteenth Century*, Eds. Catherine Gallagher & Thomas Laqueur, (Berkeley, 1987); Patricia Johnson, *Hidden Hands: Working-Class Women and Social-Problem Fiction*, (Athens, Ohio, 2001); Frank Mort, *Dangerous Sexualities: Medico-moral Politics in England since 1830*, (London, 1987), National Library of New Zealand

¹⁷¹ ‘The Health of the Army in India’, *The Saturday Review of Politics, Literature, Science and Arts*, (3rd April 1897), pp. 342-3

¹⁷² Kunal Parker, ‘A Corporation of Superior Prostitutes’: Anglo Indian Legal Conceptions of Temple Dancing Girls 1800-1914’ *Modern Asian Studies* 32:3, (Jul. 1998), pp. 559-633

prostitution and sought to sanitize religion in India.¹⁷³ There was no definition either in the Contagious Diseases Act, the Cantonment Regulation or even the Indian Penal Code Act as to what constituted prostitution. In legal terms, prostitution remained a vague category of offences, covering a wide range of sexual activity.¹⁷⁴ Nor was this the case solely in British India; the Contagious Diseases Act in Britain was equally vague. This imprecision, which could lead to ‘innocent’ women being accused or arrested, formed the basis for much of the opposition to the Act in the metropole.¹⁷⁵ However, in the colonial setting this ambiguity provided a tool for the regulation of indigent women, in a similar way to that which enabled the Criminal Tribes Act to control itinerant native groups.¹⁷⁶ The identification of marginal groups made it possible, from the European perspective, to easily identify the presumed causes of infection and ensure that it was noticeably not white. It also clearly marked the world outside the enclave as exotic and unsanitary.

For modern scholars it is difficult to ascertain intimate details of individual lives of the women that prompted such control. It is, though, possible to establish this group’s likely social composition. The women identified as common prostitutes were marginalized by poverty and received minimal support from their own society; both because of their gender and their cultural position. The arrival of the British in India had seen the rapid growth of urban centres and the concurrent development of an urban sex trade.¹⁷⁷ It is possible to argue that the brothels in these urban centres offered one of the few opportunities for employment and, to a degree, independence for some women. During

¹⁷³ Ibid.

¹⁷⁴ Ibid.

¹⁷⁵ Walkowitz, p. 175

¹⁷⁶ Yang, pp. 108-127

¹⁷⁷ Banerjee, pp. 2461-2472

the 1860s the majority of Calcutta prostitutes fell into one of two groups – either those known as hereditary prostitutes or poor village women.¹⁷⁸ Whilst this information does not refer specifically to the Madras presidency, it seems unlikely that the origin of the women would have differed substantially between the regions. The women who came from the villages were generally widows or “fallen women”.¹⁷⁹ Widows, especially Hindu widows, suffered a significant loss of status with the death of their husband; being considered inauspicious, especially if there were no children from the marriage. Similarly women who had been raped or seduced underwent a comparable loss of position and family support. There is the possibility that prostitution offered a form of economic independence for these women, who would have struggled to find ways of supporting themselves.¹⁸⁰ It appears that the women were generally from the lower castes and Hindu rather than Moslem, however, this interpretation is subject to some reservation as Moslem women often disguised their faith.¹⁸¹ Moslem widows did not have the same cultural stigma attached to them, which made remarriage more common for them. Hindu women of the nineteenth century rarely had this option, which created among them a greater economic necessity. This would suggest that the lower numbers of Moslem versus Hindu possibly were an accurate representation. Although the majority of prostitutes were indigenous, there were other races working in brothels in India, including some Europeans. As Levine has noted, the numbers of European women were always tiny in comparison to native women and the attention focused on them was out of

¹⁷⁸ Ibid.

¹⁷⁹ Ibid.

¹⁸⁰ Nandy, p. 6; see also Geraldine Forbes, *Women in Modern India*, (Cambridge, 2004), p. 19

¹⁸¹ Banerjee, pp. 2461-2472

proportion to their actual numerical strength.¹⁸² The women who were the primary focus of regulation were therefore most likely poor, indigenous women with few opportunities available to them within their own communities. From the colonial governments' perspective, this meant that efforts to regulate these women would elicit negligible native condemnation or, indeed, attention. In the same way as leprosy sufferers were isolated by their society, so too were the female prostitutes. The low social status of both groups within their own and colonial British society effectively made these people susceptible to greater societal interference.

The Contagious Diseases Acts were gendered and racialized in their use of language and choice of target. The classification of prostitutes can be seen as an extension of this. The categorization of these women identified them as a marginal, exploitable group. This was a reflection of a more general move by British colonial authority. Classification was not unique to the prostitutes, but was an aspect of the British government's efforts at regulating Indian society as a whole. From the European perspective, this classification already existed within the society in the form of caste and religious divisions.

Understanding this would provide the basis for understanding Indian society as a whole.¹⁸³ Census taking had begun as early as the 1820s.¹⁸⁴ However, British knowledge and application of the caste system was flawed, as was the collection of census data. This was in part due to the nature and framing of the questions asked, as well as a result of the responses provided, often through a translator.¹⁸⁵ Consequently,

¹⁸² Levine, *Prostitution, Race and Politics*, p. 205

¹⁸³ Cohn, 'The Census' pp. 224-254

¹⁸⁴ Ibid.

¹⁸⁵ Ibid.

the British evolved many mistaken ideas about indigenous culture, including, as mentioned above that of a prostitute caste. Prostitutes were divided, firstly into two classes: those who serviced Europeans and those who did not.¹⁸⁶ Secondly, those servicing the European clientele had to be registered and thus subject to the rules of cantonment. Authorities believed the native prostitute to have no shame or concern over their examination by British medical staff.¹⁸⁷ British sensibilities in India seem to have been alleviated by this notion, which meant the indigenous culture was responsible for the presence of prostitutes and not white men. Throughout the colonial territories of the British Empire, Contagious Diseases Acts reflected the racial nature of the legislation when directed at a non-European population.¹⁸⁸ This was in contrast to the metropole, where prostitution had become an area of much social debate and criticism, particularly following the introduction of the Contagious Diseases Act.¹⁸⁹ This also made it possible to easily target a specific group – in this case indigenous women – as the source of infection. One memorandum from the Quartermaster General in India and addressed to the General Officers Commanding Divisions and Districts emphasised the men's responsibility was in 'indicating the women from whom disease has been acquired.'¹⁹⁰ Although the memorandum goes on to advise that detachments should undergo medical inspection before departure, prosecution and exclusion were directed only at women. Army doctors were to examine the prostitutes, confine the diseased for treatment and

¹⁸⁶ Banerjee, pp. 2461-2472

¹⁸⁷ The Special Committee noted that "Prostitutes in India usually form a separate, well-recognised body to which public opinion hardly attaches disgrace..." *Special Committee's Exposition of the Lock Hospital Rules*

¹⁸⁸ Colonial adaptations of the Acts are succinctly covered in Philippa Levine, *Prostitution, Race and Politics: Policing Venereal Disease in the British Empire*, (New York, 2003)

¹⁸⁹ Walkowitz, p. 32

¹⁹⁰ *Circular Memorandum No. 21*, 17 June 1886, from the Office of Quartermaster General in India to General Officers Commanding Divisions and Districts, International Documents Collection, Parliamentary Library, Wellington, New Zealand

exclude the incurable. Although British doctors treated British men and Indian women for syphilis, race and gender differentiated the responsibility attributed to each for the infection; women were criminalized, men treated as victims. The maintenance of prostitutes inside the cantonment marked these women as little more than the livestock of British soldiers, who were to be the sole exploiters of them. Living inside the cantonment also isolated them from both their own society, which was outside the picket, and that within, which was European. It defined their clientele as white only and underlined the colonial assumptions of indigenous sexuality. It also clearly marked the world outside the enclave as exotic and unsanitary. The Cantonment regulations and associated official memoranda aimed to delineate visibly the suitable prostitute from the unsuitable and dangerous. While the construction of the leprosy sufferer was not as heavily gendered, the Lepers Act and the Contagious Diseases Act both created a portrait of the diseased other. A body that was visibly different – racially, socially and sexually.

While confinement for disease treatment was legislated, registration for regimental service by prostitutes was not. The responsibility for applying to be registered fell to the women themselves. In electing to register, women were voluntarily engaging with the colonial system. This is analogous with the way that many middle-class Indians chose to work with British bureaucracy. Women could opt in or out of the register; however, they must have been well aware that being on the list made them subject to many regulations including compulsory examination and possibly treatment. The constraints that prompted women to register are unclear and certainly, not all prostitutes chose to. Whether it was economic advantage or some limited form of military protection that prompted their

application is not known. A woman, who wished to have her name removed from the register, was entitled to do so, but presumably lost access to the cantonment as a result. There was also concern over the administration of the list and the potential for abuse. It was noted that women must be registered before examination and not vice-versa.¹⁹¹ The British Authorities who authored the regulations did not wish to stamp out prostitution, merely control the effects of venereal disease on the enlisted men. Prostitution was “an inevitable evil, which may be controlled, but which cannot be got rid of”.¹⁹² The women in choosing to register were actively electing to participate in a colonial system that sought to classify and contain them.

A clear focus of the regulations was the prohibition of unregistered women working as clandestine prostitutes. Unregulated and unidentified these women were invisible to authority and therefore unmanageable. The unregistered woman was unclassified, a diseased other, at whose door responsibility could be laid for infection. She was an example of the dangerously exotic. Unregistered prostitutes were prohibited from the vicinity of the cantonment, however, there was an awareness that these women were present in the bazaars that developed nearby. Authorities did note that: “The greater number of the public women of the town will be notoriously quite inaccessible to the European soldiers”.¹⁹³ Presumably this comment related to the state of the women – lack of cleanliness, drunkenness and ‘native’ clientele - rather than any difficulty of locating them. When syphilis rates did not drop, the focus was on the clandestine or “secret” prostitutes who were often accused of being the source of infection; the invisible threat of

¹⁹¹ *Special Committee's Exposition of the Lock Hospital Rules*, p. 94

¹⁹² *Ibid.*

¹⁹³ *Ibid.*

unofficial prostitutes: unregistered, uncontrolled and hidden from authority. At least one medical officer, however, thought the men were partly responsible for the continuing high rate. Surgeon Major Kearny wrote “I have no doubt in my mind that clandestine prostitution exists to some extent and that venereal disease instead of being propagated by registered prostitutes, is communicated to them.”¹⁹⁴ Kearny whilst recognising the role of the men in infection rates, still assumed uncontrolled women were the source of the disease. Lock hospital reports emphasise this pointing out the ineffectiveness of the legislation to deal with these women, who carried “the most dangerous form of disease” and entered the cantonment surreptitiously or claimed “nicka” marriage to avoid registration.¹⁹⁵ Nicka marriages were religious ceremonies, not registered with the civil authorities. Once inside the cantonment, women could, at least according to the military, engage in part-time prostitution, further fuelling suspicions about all native women. In essence the British authorities were further classifying prostitutes into visibly managed and healthy versus the hidden, uncontrolled and diseased; good women versus bad women. The good prostitute was registered, uninfected and served only British soldiers. The good prostitute could be incorporated into the British view of itself in India – control of a necessary vice. The bad was unregulated, probably infected and serviced any customers she wanted and was essentially uncontrolled. The ineffectiveness of treatment was blamed on these women as they became a metaphor for unclean, exotic dangers.

Although Walkowitz was writing of working class prostitution in the metropole, the same

¹⁹⁴ Extract report by Surgeon Major D Kearny, St Thomas’ Mount Lock Hospital Report, 1873, Annual Report of the Lock Hospitals of the Madras Presidency 1874, p. 77 *Selections From The Records of the Madras Government*

¹⁹⁵ H. Stanbrough, Health Officer and Superintendent, Lock Hospital, Madras, 16th April 1874, Annual Report of the Lock Hospitals of the Madras Presidency 1874, p. 77 *Selections From The Records of the Madras Government*, p. 389, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

paradigm applied in India: “Pollution became the governing metaphor for the perils of social intercourse between the Two Nations.”¹⁹⁶ By making a distinction between the registered and unregistered woman the colonialists were seeking to control their environment and differentiate the European cantonment from the indigenous bazaar; the acceptable native from the unacceptable, uncontrolled native.

Classification and containment, two crucial elements of the legislation made it necessary to identify the diseased women. By electing registration, women sanctioned the privileges of British male doctors to access their bodies and the right to imprison them based on biology. Both the Cantonment Regulations and the Contagious Diseases Act aimed to detect venereal disease, primarily syphilis, in order to prevent the spread of the disease to others. In the case of the Cantonment Regulations, detection was to be through the regular examination of the registered prostitutes by, the primarily, male medical staff. At many levels however women colluded with authorities to support the regulations. The favoured method for identifying the women for full examination was the use of an elderly matron or *dhai* to initially check for venereal diseases. The *dhai* then ensured that the infected women were presented for treatment. Lock Hospital Funds paid for the *dhai*, who also had responsibility for the cleanliness of the women, ensuring the upkeep of their housing, as well as acting as the point of contact for authorities – notifying them of arrivals, departures and changes of status.¹⁹⁷ Here again, women opted to participate in the colonial system, with one group of women achieving a certain status through employment by the military authorities. Generally, the *dhai* reported women she

¹⁹⁶ Walkowitz, p. 4.

¹⁹⁷ *Special Committee's Exposition of the Lock Hospital Rules*, p. 95

considered infected to the Lock Hospital authorities and the army medical officers completed a full pelvic examination.¹⁹⁸ There is some debate that it was these examinations that were at least partially responsible for the spread of the disease.¹⁹⁹ This is certainly possible, as there was little in the way of sterilisation of equipment between patients and the number of inspections by a doctor in one day.²⁰⁰ One of the major flaws in the system however, lay in the belief that syphilis could be diagnosed by a brief visual examination at an early enough stage to prevent infection of others. Despite the best efforts of staff and indeed the women themselves infection rates did not decrease as a result of the Cantonment Regulations. Regardless of effectiveness, however, women elected to register as regimental prostitutes, with visible classification and examination of their bodies which registration entailed.

As noted above the clandestine prostitute was seen by the military as a particular danger to the young soldier. The visible, registered prostitute was seemingly considered safe, whereas the invisible, uncontrolled female was regarded as a significant danger and marked as more threatening to military power. Following the introduction of short service in 1870 – an enlistment period of seven years - the number of young single men present in India increased dramatically. As Major General Chapman pointed out in his memorandum of June 1886 to Commanding Officers: “If young soldiers are carefully advised...they may be expected to avoid the risks involved in association with women

¹⁹⁸ Linda Bryder, ‘Sex, Race and Colonialism: An Historiographical Review’, *The International History Review*, 20:4, (Dec. 1998), pp. 806-822

¹⁹⁹ Bonnie S. Anderson and Judith P. Zinsser, *A History of Their Own: Women In Europe From Prehistory to the Present*, (New York, 1989), p. 265

²⁰⁰ Ibid.

who are not recognised by the regimental authorities.”²⁰¹ Sir Alexander Arbuthnot, a member of the Council of India was more concerned about the potential danger to the metropole. Writing in the Minutes of Dissent to the Despatch addressed to the Secretary of State in June 1888, he noted:

There is a grave danger, if these young men are not, as far as possible, protected from those virulent forms of venereal disease..., that they after they return home, marrying... will infect innocent women, and bring into the world children tainted from their birth with the consequences of a loathsome disease.²⁰²

The object of concern was the common soldier. The references made it clear that these men were not the officers, but those drawn from the lower, working classes of Victorian society. Arbuthnot in the same document clearly stated the class basis of his perception of syphilis, that the infection affected that section of society from whom the common soldier was drawn.²⁰³ The comments by military authorities made it clear that the uncontrolled female prostitute posed a risk to the ill-disciplined lower ranks, in the army and at home, who according to the class prejudices of the time were less able to control their sexual appetites.

²⁰¹ *Circular Memorandum No. 21*, 17 June 1886, from the Office of Quartermaster General in India to General Officers Commanding Divisions and Districts, International Documents Collection, Parliamentary Library, Wellington, New Zealand

²⁰² General Alexander Arbuthnot, *Minutes of Dissent by Certain Members of Council of India from the Despatch Addressed by the Secretary of State to the Government of India regarding the Contagious Diseases Act*, (May 1888), International Documents Collection, Parliamentary Library, Wellington, New Zealand

²⁰³ *Ibid.*

A further component of the regulations, following registration, prohibition and detection of venereal disease, was the detention and treatment of infected women. The Contagious Diseases Acts used its primary controlling space for the removal of the visibly diseased, lower class female for the protection of the lower class male. For the purposes of treatment and detention the essential facility required was the lock hospital. These hospitals were part medical institution, part prison. The women taken to them were confined for compulsory examination and medical treatment. Here, the body of the prostitute underwent what the Act's opponents would refer to as legalised, instrumental rape.²⁰⁴ Lock hospitals had been in existence since the seventeenth century and all of them focused on the containment of women. In the metropole these hospitals incorporated not just treatment and imprisonment, but morally and class based efforts to reform the character of the inmate. Metropolitan societal authorities attempted the reintegration of the 'fallen' as productive members of society, with the retraining of prostitutes in suitable careers – such as domestic service.²⁰⁵ Along with this was regularly included evangelical preaching, which aimed to save the soul of the fallen woman. British efforts in India had important differences, the women's race made them outsiders to the white society because of their race and there was little or no effort to convert or retrain them – reintegration was not essential. The women had an assigned societal role already, the lock hospital served to regulate the visibility of the diseased body, in the same way that the leper asylum did for those suffering from leprosy. The focus of the efforts of the acts and its special application was on the removal of a visible threat and protection of white males from infection.

²⁰⁴ Andrew & Bushnell, p. 10

²⁰⁵ Walkowitz, p. 223

Gender was a factor in the Contagious Diseases Acts and the Lepers Act; however, it was most overt in the former. The impact of gender on the Lepers Act was implicit and based on biological and cultural factors. While cultural factors were certainly at play in the Contagious Diseases Acts, the wording and implications of the act were focused solely on women. In application, however, there were distinctions made as to which women were subject to the control by the Acts. Race and class proved to be as important to the operation of the act as gender and are inextricably linked to its operation. As can be seen in the application of the act in both India and the Metropole, lower class women and their patrons were the target. In India, this was further compounded by colonial ideas of Indian culture and assumptions about indigenous sexuality. The interaction of race, class and gender created tensions in the operation of the acts; in particular the management of the visibly diseased body. The acts attempted to conceal the poor diseased body, or at least, regulate its presence. The Contagious Diseases Act identified the visible prostitute as regulated, although she was rendered invisible if she developed venereal disease. Once in the lock hospital her diseased body was effectively within the control of the medical staff there. The invisible – ‘clandestine’ – prostitute was unregulated and dangerous. Colonial authority marked the officially visible prostitute as safe and, while there were other women present, their unofficial status marked them as a risk. When infection rates failed to drop, the threat was deemed to extend from the unofficial, invisible women. This same tension existed in the Lepers Act, although not all lower class Indian men were considered a risk as was the case with the Contagious Diseases Acts.

Space:

Spatial separation was a growing feature of Victorian culture, not just when related to dirt and disease, but throughout society. Hall has stated that constructed bodily categories marked the differences of hierarchy and that constructed physical spaces formed a part of this.²⁰⁶ Certainly, with leprosy and syphilis the physical separation of the diseased body from the public space was a crucial feature of colonial approaches to management.

Europeans, particularly following the events of 1857, deliberately established housing settlements in areas distinct from the indigenous.²⁰⁷ In part, this can be attributed to a feeling of insecurity in the tightly packed cities. However, another important element was the continuing belief in the environmental paradigm of disease transmission along with the association of dirt and disease with the 'native' influence.²⁰⁸ The restriction of indigenous movements within European spaces was a reaction to health, safety and military security fears. Cantonment regulations controlled natives, especially native women in and around the area.²⁰⁹ Hospitals delineated patients according to race and classified their reported figures in the same way. In some instances there were different facilities for different classes and races. This even applied to institutions established for

²⁰⁶ Hall, *Civilising subjects*, p. 17

²⁰⁷ Collingham, p. 165

²⁰⁸ Arnold, p. 80

²⁰⁹ Cantonment Regulations

the native population, where there was an awareness that European facilities would not be used if the ‘wrong’ people were included. At one infirmary, it was reported that women from good families were staying away because prostitutes also attended for treatment.²¹⁰ Aside from spaces assigned to the sick, there was the imposition of these physical boundaries on the potentially infected. Brothels were categorized according to their client pool and those with leprosy could only use certain public facilities.²¹¹ Colonial power in India created corporeal hierarchies based not just on differences of race and class, but also on geographic position.

The location most associated with the sufferers of leprosy and syphilis was the hospital or asylum. The Lepers Act sent those convicted to an asylum, whereas the Contagious Diseases Act confined women to a lock hospital. The concept of the ‘total institution’, conceived by Irving Goffman in the early 1960s has been an influential model for examining the operation of these hospitals.²¹² Subsequently, numerous historians have used this work as an analytical framework.²¹³ The paradigm of the ‘total institution’ continues to provide an important basis for the analysis of space and its use in the control of its residents. Arguably the leper asylum and the lock hospital could have permanently marked the inmates. However, whilst these facilities fit the description of two of Goffman’s five types of ‘total institution’ the reality would suggest that neither can be

²¹⁰ Arnold, p. 250

²¹¹ *Special Committee’s Exposition of the Lock Hospital Rules*; The Lepers Act, Section 9 – Power to prohibit lepers from following certain trades and doing certain acts

²¹² Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Chicago, 1961)

²¹³ Amongst the many to refer to Goffman’s work are Joseph, Buckingham and Ignatieff, all referenced here

truly considered as such.²¹⁴ Of the five Goffman described, it is the second and third type, which could be applied to the leper asylums and lock hospitals. The second undertook the care of those people incapable of their own care, who also represented a threat to the community, whereas the third's main concern was the protection of the community.²¹⁵ Arguably, lock hospitals fit into the third category as the women confined were clearly capable of care for themselves and it was their danger to the wider population that was at issue. Possibly leper asylums could be considered as part of this category as well, however, leprosaria were one of Goffman's examples in the second category. Certainly neither institute fitted neatly into any one of the categories described. Nor did they meet all of the criteria set out to describe the effect, supervision or treatment of inmates. Of the characteristics listed by Goffman only two are completely applicable, that being the centralisation of place and the restriction of knowledge.²¹⁶ Other than these, the leper asylum and lock hospital have little in common with the concept of total institutions. The most obvious refutation of the designation was the porous nature of the boundaries. Neither facility ostensibly allowed the inmates to leave without permission, requiring the agreement of medical staff before exit; however, this was not the reality. Leprosy sufferers were a mobile population, moving between asylums.²¹⁷ Although there was the potential within the Contagious Diseases Acts for women to be permanently incarcerated, in practice it was rarely the case as women were known to make return visits.²¹⁸ The organisations of life within the facilities also disproved the idea of total

²¹⁴ Goffman, *Asylums*, pp. 4-5

²¹⁵ Ibid.

²¹⁶ Goffman, *Asylums*, p. 6

²¹⁷ Kakar, pp. 215-230

²¹⁸ All the Lock Hospital Reports support this. See for example: Annual Report of the Lock Hospitals of the Madras Presidency 1873, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

control. There was little attempt to fully regulate the life of the patients, contact with the wider community may have been limited, but it was not non-existent and ultimately, the official aims of these institutes was unachievable, thereby undermining their ability to exert significant control over those confined.

Although the leprosy asylum and the venereal lock hospital did not conform to the label of total institutions, their function was still one of spatial control. The focus for authorities was on the relocation from an external public space to an internal medical space. As Sammett has asserted, the control of space transforms the visible and reveals the class/gender and, in the colonial context, racial hierarchy of a society.²¹⁹ However, with these two institutions in India, beyond the removal from the public sphere and therefore the public gaze, there was little effort to effect behavioural transformation within the medical space. Treatments were applied which aimed to effect bodily transformation, through cure. However, given the effectiveness of treatments, this could be interpreted as no more than an expression of medical authority over the diseased body. All the women of the lock hospital received the same care, in terms of daily needs, as one another; presumably based on the assumption that only the lower castes would undertake the function of a prostitute. Asylum patients did receive recognition of their religious differences, however, there was limited spatial differentiation for this or possible caste differences and there is no evidence that food or facilities altered according to social

²¹⁹ Kai Sammett, 'Controlling space, transforming visibility: Psychiatrists, nursing staff, violence and the case of haematoma auris in German psychiatry c. 1830-1870' in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context* Eds. Leslie Topp, James E. Moran and Jonathan Andrews (Routledge, New York, 2007) pp. 287-304

position.²²⁰ This was in contrast to the asylums for the mentally ill both in India and Europe. European asylums of the same period offered better facilities and more care to those patients from higher social classes than those from lower social strata. In India this delineation was replicated and extended to include racial and religious considerations.²²¹ The underlying cause of this disparity in asylums may lie in the success or otherwise of the doctors treating the patients. Foucault's objectifying medical gaze meshes with Sammett's insight that "Looking meant banning madness; meant exercising power over it; meant healing."²²² The perceived potential for the cure of madness necessitated the greater control of the patient, however, for the indigenous leprosy and syphilis sufferer this possibility did not exist thus eliminating the motivation for individual restriction in the private sphere. This retreat from the private space also ensured that there was a smaller chance of contestation with indigenous middle-classes over British intervention, as there had been with plague legislation.²²³ Colonial authority controlled the appearance of the public sphere and demonstrated its power by the elimination of undesirable types transforming the visible environment, but essentially leaving the private individual intact, if relocated.

The reasons for this control of the public, but not the private spaces of India can perhaps be found not only in the British view of themselves in India, but also in their image of empire on the sub-continent. Many other colonial spaces were seen as areas where the

²²⁰ Papers relating to The Treatment of Leprosy in India from 1887-1895, Selections from the Records of the Government of India, University of Canterbury (microfilm)

²²¹ Waltraud Ernst, 'Madness and Colonial Space – British India, c. 1800 to 1947' in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, Eds. Leslie Topp, James E. Moran and Jonathan Andrews, (Routledge, New York, 2007), pp. 215-238

²²² Sammett, pp. 287-304

²²³ Ira Klein, 'Plague, Policy and Popular Unrest in British India', *Modern Asian Studies*, 22: 4, (1988), pp. 723-755

homeland could be recreated, places such as New Zealand, Canada and Australia. India, however, was a manufactory colony, a place of trade, import and export, and not a residential one. Permanent settlement was not a part of the British psyche in India.²²⁴

The exploitation of the area's resources was the primary purpose for British presence, few Europeans sought to make India home. Assimilation or annihilation, accidental or otherwise, was not an option in a land with millions of residents. The British had to share the public spaces with the indigenous population, whilst at the same time distancing themselves from this very same group. European housing was part of major conurbation, but at the same time separate from it in position and design.²²⁵ However, those affected by leprosy and syphilis did not necessarily fall in with this neat stratification. Vagrants and prostitutes chose their sites of trade. References in documents and newspapers make this clear. One parson complained that the women in the lock hospital sat outside brushing their hair and looking disreputable; the hospital was opposite his church.²²⁶ The hospitals, asylums and even brothels reflected an attempt to regulate the movement and appearance of these public spaces. Not only did the coloniser remove the undesirable from their milieu, they also in a sense removed themselves from the everyday lives of the locals. As Ernst has succinctly put it "unless the practicalities of military or domestic service required spatial proximity, British ideas about social class divisions and the perceived propriety... (kept) the different strata of society apart".²²⁷ This dichotomy was interwoven with racial stereotyping both of whites and natives. Arguments about

²²⁴ Ernst, pp. 215-238

²²⁵ Collingham, p. 165

²²⁶ Series XI: Prostitution and Lock Hospitals at Military Stations, Reports on Mountain and Marine Sanitaria, (Madras, 1862) *Selections From The Records of the Madras Government*, p. 389, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

²²⁷ Ernst, pp. 215-238

preserving European health by avoiding contact with local customs were common.²²⁸

The stratification of society and the resulting classification were essential components of the colonial perception of order and propriety.

Definitions of separate spaces developed during the nineteenth century in India and lines were drawn socially and physically. With the memory of the events of 1857 still fresh, Europeans in India attempted to distance themselves from the indigenous population.

Socially, the British cultivated an air of aloofness towards indigenous colleagues.²²⁹

Physically, new cantonments and settlements were deliberately established outside existing native urban settlements.²³⁰ The indigenous became something to fear, the exotic was now unhealthy. Bazaars were now seen as dirty and a potential source of infection.²³¹ The cantonment regulations, which aimed at controlling the military spaces, sought to manage the interactions of white soldiers with all natives. The women, who elected to register on the list of prostitutes, did so with an acceptance of these spatial rules. Effectively they were choosing their consumers and the space where they did business. Registered prostitutes were asked to inform authorities of unregistered women operating in the cantonment; some certainly complied and reported other women.²³²

Clearly women were negotiating and contesting space, as well as engaging with colonial authority to do so. Women on the register negotiated using the terms defined by authority and adopting privileges accorded by Cantonment regulations. While the

²²⁸ Arnold, *Colonizing the Body*, p. 89

²²⁹ Collingham, p. 151

²³⁰ Collingham, p.165

²³¹ Arnold, *Colonizing the Body*, p. 89

²³² Annual Report of the Lock Hospitals of the Madras Presidency 1873, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

unregistered woman contested the space and the right of authority to define it, her presence around the cantonment defied colonial restrictions. The space where the native prostitute could meet her European client was specific. The brothels, *chaklas*, or rags, as the British troops called them, were split into one of three categories: white officers, white enlisted and native enlisted.²³³ This categorisation of *chaklas* also demonstrated the colonial elite's attempts at spatial segregation from the lower classes. However, it should not be assumed that the creation of rules around space made this the reality. All of the barriers which the British authorities constructed were extremely porous. The constant references to the clandestine prostitute or dangers of bazaar alcohol in official reports suggest that neither the soldiers nor all prostitutes were interested in adhering to artificial boundaries between the social groups.

As noted above the Contagious Diseases Act initially operated between 1868 and 1884, and during this period there were upwards of a dozen lock hospitals operating in the Madras Presidency. At any one time during most of this period, between nine and ten of these were military. There were two hospitals that were generally considered civilian – Madras City and Rangoon. This designation could change with military hospitals becoming civilian and vice-versa. Rangoon exemplified this. In 1872 its designation was civilian. Prior to this its identification was as a military hospital. In 1876 there were four civilian hospitals, which included two former military sites.²³⁴ The cost of these hospitals, excluding the civilian ones, was borne by the military. According to the lock

²³³ Banerjee, pp. 2461-2472

²³⁴ Annual Report of the Lock Hospitals of the Madras Presidency 1876, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

hospital reports the admission rate for European troops was approximately fifteen per thousand.²³⁵ This rate appears low because the majority of men were not admitted, but treated as out-patients.²³⁶ The rate of women admitted was substantially higher, with the 1873 Lock Hospital report stating that all the nearly one thousand registered prostitutes had been hospitalised at least twice.²³⁷ The fact that the women underwent multiple treatments suggests that there was more mobility amongst the patients than implied by the wording of the act. The reports do not breakdown the length of hospital stay by gender; they do, however, provide an average. The average hospital stay was only around one month. Syphilis and gonorrhoea were the two most prevalent infections noted. Syphilis was broken down into primary and secondary. Tertiary syphilis was not mentioned, although there were deaths listed that are attributed to the disease. On average these hospitals of the Madras Presidency were treating around a hundred and fifty soldiers a day. Despite women being the main in-patients of the lock hospitals, reports focused on the increase or decrease of disease amongst men/soldiers. There appeared to be an assumption that the disease was an inevitable occupational hazard for the women and the main purpose of the hospitals remained the safeguarding of British lives.

When the Act was repealed 1888, these hospitals did not automatically close down.

Instead, they remained operational and became 'voluntary' centres for treatment.

²³⁵ Annual Report of the Lock Hospitals of the Madras Presidency 1873, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

²³⁶ George R. Dartnell, 'On the Prevalence and Severity of Syphilis in the British Army; and its Prevention', *British Medical Journal*, (28th April 1860), pp. 317-319

²³⁷ Annual Report of the Lock Hospitals of the Madras Presidency 1873, *Selections from the Records of the Madras Government*, Selections from the Records of the Government of India, University of Canterbury Library (microfilm)

However, given that many of the buildings remained within the cantonments and therefore within the control of the military authorities, levels of unofficial pressure could be applied to women to compel attendance for treatment. In Bushnell and Andrews' report on the situation in India in 1897 the hospitals, despite official assurance to the contrary, were very much operational.²³⁸ Many in the military lamented the repeal of the Contagious Diseases Act and argued that venereal disease rates had risen as a result of this.²³⁹ One suggestion, put forward as a benefit of the lock system, was that the hospitals provided centralisation of the confined women for philanthropic efforts, although there was little evidence that this actually happened.²⁴⁰ British authorities had established other medical treatment centres in India including civil hospitals and dispensaries which provided both in and outpatient care. These facilities had the potential for use as an alternative to the militarised lock hospital system. However, as Harrison has pointed out, the dispensaries were not that successful in their treatment of women.²⁴¹ Further, there were cultural problems with the patients of dispensaries. Prostitutes attending a public dispensary were likely to offend the sensibilities of respectable women.²⁴² Although becoming ostensibly voluntary, the lock hospitals' primary function continued for some time. Clearly the popularity of visibly controlling a perceived threat to military welfare was undiminished by repeal of the Act.

²³⁸ Andrew & Bushnell, p. 14

²³⁹ Andrew & Bushnell, p. 34

²⁴⁰ 'The Health of the Army in India', *The Saturday Review of Politics, Literature, Science and Arts*, (3rd April 1897), pp. 342-3

²⁴¹ Harrison, *Public Health*, p. 89

²⁴² Arnold, *Colonizing the Body*, p. 250

Geographical boundaries gave concrete evidence of societal hierarchies. Space, particularly public space, was one marker of the constructed bodily categories such as race, class and gender. Control of these spaces was a tangible demonstration of the power of colonial authority. The presence of the diseased body was regulated by legislation, which allocated it to private spaces, away from the public space and gaze. The Lepers Act and the Contagious Diseases Acts attempted to manage the bodies of people suffering from leprosy and syphilis, especially those with low social status and visible symptoms. A key feature of this management was the supervision of the space that the body inhabited. In India, however, once within that space, while the body underwent medical treatment, the spiritual and intellectual behaviour of the patient was not an issue. This was in stark contrast to the way in which sufferers were dealt with in the Metropole, where occupational and religious training were common place. Further, the space occupied by leprosy sufferers and prostitutes was never uncontested. The vagrant leprosy sufferer moved between towns and asylums; thereby negotiating where they stayed and for how long. Women working as prostitutes could elect to work either within the official space or not; each arena offered different advantages. Even the length of stay within a lock hospital was negotiated. A cure was unachievable, and yet women did not remain permanently confined. Tensions arose, however around the visibility of the diseased body in public spaces. Removal from the public space demonstrated colonial power; conversely the presence of the diseased body indicated a lack of control. Corporeal presence within regulated of space, most importantly public space, was thus a central contestation point in colonial society.

Overtly, the Lepers Act and the Contagious Diseases Act sought to control people visibly infected with leprosy and syphilis. In order to achieve this, the legislation constructed the bodily categories of the diseased. These categories were an amalgamation of British cultural views that were based on assumptions of race, class and gender. This view was then tempered by the need to placate the Indian elite classes, who were essential to the British colonial government. British authority and local elite, especially in relation to the Lepers Act, negotiated the interpretation of the diseased body. Indian upper-castes sought to preserve their social position and protect themselves from potential abuses of civil rights. Thus, while the archetypal leprosy sufferer was constructed as indigenous, he was also seen as poor, indigent and male. In a similar way, the Contagious Diseases Act targeted poor, lower-caste females. The legislation further emphasized the social hierarchies by the control of the space inhabited by the visibly diseased body; the management of space being a key marker of social position in nineteenth century British colonial and metropolitan societies. Both Acts permitted the removal and confinement of people to government nominated institutions, the lock hospital and the leper asylum. These spaces were not, however, uncontested. Those targeted under the legislation often elected to operate within or without these boundaries. Women chose to register as a prostitute, or worked unofficially in cantonments. Confinement in a lock hospital was not permanent and some women made repeated visits. Vagrant leprosy sufferers were equally mobile, moving between different cities and asylums. At all levels of Indian society there was interaction, negotiation and defiance of colonial authority. The legislation may have constructed a visibly diseased body and then attempted to control it;

however it was only ever a compromised embodiment that was permitted by the society in which it operated.

Conclusion

The Lepers Act and the Contagious Diseases Acts cannot be understood as merely attempts to protect the welfare of the population. Given that little was known about the diseases and the lack of any successful treatment, the introduction of laws to control them appeared as misguided, even to contemporaries. The examination of the legislation demonstrates that it combined legality with medical expertise in order to support British colonial authority. Leprosy and syphilis, in particular, engendered this response not because of their biological consequences, but because of their psychological effect. The imagined significance of these diseases was greater than any real risk posed by them. For the British in India, leprosy and syphilis were interpreted through the lens of European understanding and history. The response of colonial authority was not related to Indian concepts of these diseases, nor did the legislation use local law as a framework for the creation of the two relevant statutes. The metaphorical characterisation of leprosy and syphilis were embedded as cultural references and underscored colonial reaction to the visible presence in India. Both diseases were burdened with concepts of morality, class, race and gender. Syphilis was the medically more threatening of the two, with its high levels of infection and potential fatality. However, it is possible to argue that the fear of the disease was even greater than the actual risk of the disease itself. The health of the army, particularly in a colony as large as India, was of vital importance. Highly visible infection amongst the soldiery weakened British authority and weakened the European claims to racial superiority. In British India, leprosy embodied the primitiveness of the colonised, the civilizing mission of the colonizer and the superiority of the white races

over the indigenous. With the failure of western medicine to successfully cure the disease however, leprosy, as well as syphilis, were also a challenge to that colonial authority.

Legislation to control syphilis and leprosy arose as a result of British fears and perceptions of imperial weaknesses. The language and application of the acts shared a historical foundation, which had its origins in British cultural markers, as well as colonial assumptions of Indian culture. In their formation, however, the Lepers Act and the Contagious Diseases Acts also reified cultural stereotypes. British laws in India were an attempt by colonial authority to not just regulate, but also classify, indigenous society. In a very important way, the law acted as a cultural marker of the constructed visibly diseased body. The prevalence of syphilis and the potential impact on the economic and military wellbeing of the Empire made legislation almost inevitable. It was introduced far earlier than leprosy legislation and with little debate. The Contagious Diseases Act created a socially acceptable, visibly controllable vector, the common prostitute. The Lepers Act, by contrast, was the outcome of intense debate and negotiation. Amongst the various elite Indian groups, the prime motive for contesting the Act appeared to be the protection of the individual's rights, but only for those individuals who were part of the upper strata of society. There was little concern over the welfare and much support for the control of the diseased poor. Due to the degree of conciliation required to pass the Act, the outcome produced an emasculated piece of legislation that was almost unenforceable. The response of the colonial British government to both diseases was one of containment and concealment. Visible leprosy and syphilis sufferers were to be

removed from the streets and confined potentially for life, although in reality this was not the case. Noticeably, the constructed other implicit in both pieces of Indian legislation was one that was already marginalised by their own society, thereby reinforcing the stereotypes of the colonised and the coloniser.

The body that was the target of leprosy and syphilis legislation was a construction originating in British cultural markers. Crucial to the constructed diseased body were identifiers of race, class and gender. In India, racial differences were an important visible marker of hierarchy. These differences also identified indigenous communities as exotic and a possible health risk for the British population. While not as visible as race, class was as significant to identity. The social hierarchy of the metropole was present in Anglo-Indian culture, and contributed to the colonial authorities making assumptions about the Indian caste system. In Britain, as in India, during the nineteenth century, the lower classes were associated with disease and ill-discipline. This was the same in India. The visibly diseased body of the leprosy and syphilis sufferer was identified as distinctly lower class/caste. Ostensibly, of the two, only the Contagious Diseases Acts were specifically gendered. However, the Lepers Act encompassed an implicit gendered nature, although it was not written into the Act. In India, as elsewhere, the Contagious Disease Act had an explicit gendered focus. Added to this were mistaken colonial characterisations of indigenous culture and sensitivities. Native cultural mores already placed these women on the edges of their own society. Consequently, local elite raised few objections to the restrictive legislation and the containment of these women. Once identified, the visibly diseased could then be regulated and confined. Colonial policy

attempted to engender distinctive boundaries between the races and classes of society. The nineteenth century was a period of spatial separation, although this was not to say that these acts were entirely uncontested. The underlying feature of the Contagious Diseases Acts and the Lepers Act was the regulation of groups that fell outside the mainstream. Overtly attempting to control disease, these acts constructed a visible embodiment of the disease. They then had a corporeal symbol on which to act. These pieces of legislation sought to manage the space the diseased body inhabited as a demonstration of colonial power and authority. Colonial imagining of disease, poverty, race and authority engendered an environment where the visible victims of a disease were the target rather than the disease itself.

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